BlueCross BlueShield of Montana : **Blue Preferred Silver PPO**^{SM} **308**

Coverage for: Individual/Family | **Plan Type:** PPO

⚠️ **The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately.**
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsmt.com/bb/ind/bb_spsh44ppoimto_mt_2024.pdf or by calling 1-855-258-8471. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In-Network: $8,150 Individual / $16,300 Family Out-of-Network: $32,600 Individual / $65,200 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.
Are there services covered before you meet your <u>deductible</u>?	Yes. In-Network <u>Preventive Care</u> services, <u>prescription drugs</u>, and In-Network hospice are covered before you meet your <u>deductible</u>.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other <u>deductibles</u> for specific services?	Yes. Inpatient Out-of-Network Facility $2,000; Outpatient Surgery Facility Out-of-Network $2,000. There are no other specific <u>deductibles</u>.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In-Network: $8,150 Individual / $16,300 Family Out-of-Network: $32,600 Individual / $65,200 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u>, <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbsmt.com/bluepreferredppo or call 1-855-258-8471 for a list of In-Network providers.	This <u>plan</u> uses a <u>provider</u> <u>network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u>.

> ⚠️ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge after deductible	No Charge after deductible	Virtual Visits: No Charge after deductible. See your contract* for details.
	Specialist visit	No Charge after deductible	No Charge after deductible	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	No Charge after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	No Charge after deductible	Preauthorization may be required; see your contract* for details.
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	No Charge after deductible	Preauthorization may be required; see your contract* for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/bb/ind/bb_spsh44ppoimto_mt_2024.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsmt.com/rx24/6T	Generic drugs (Preferred)	Retail: Value - $10/prescription Participating - $20/prescription Mail: $30/prescription; deductible does not apply	Retail: $20/prescription; deductible does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs are limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic drug equivalent may also be required if a generic drug equivalent is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copay/coinsurance. Additional charge will not apply to any deductible or out-of-pocket amounts. A covered insulin drug will not exceed $25 copayment for a 30-day supply.
	Generic drugs (Non-preferred)	Retail: Value - $15/prescription Participating - $30/prescription Mail: $45/prescription; deductible does not apply	Retail: $30/prescription; deductible does not apply	
	Brand drugs (Preferred)	Retail: Value - $50/prescription Participating - $100/prescription Mail: $150/prescription; deductible does not apply	Retail: $100/prescription; deductible does not apply	
	Brand drugs (Non-preferred)	Retail: Value - $100/prescription Participating - $150/prescription Mail: $300/prescription; deductible does not apply	Retail: $150/prescription; deductible does not apply	
	Specialty drugs (Preferred)	$250/prescription; deductible does not apply	$250/prescription; deductible does not apply	
	Specialty drugs (Non-preferred)	$500/prescription; deductible does not apply	$500/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	$2,000/visit plus plan deductible	Preauthorization may be required. For Outpatient Infusion Therapy, see your contract* for details.
	Physician/surgeon fees	No Charge after deductible	No Charge after deductible	
If you need immediate medical attention	Emergency room care	No Charge after deductible	No Charge after deductible	None
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	Preauthorization may be required for non-emergency transportation; see your contract* for details.
	Urgent care	No Charge after deductible	No Charge after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	$2,000/visit plus plan deductible	Preauthorization required.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/bb/ind/bb_spsh44ppoimto_mt_2024.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No Charge after deductible	No Charge after deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	No Charge after deductible	Virtual Visits are available. Preauthorization may be required; see your contract* for details.
	Inpatient services	No Charge after deductible	$2,000/visit plus plan deductible	Preauthorization required. Residential treatment facilities will be covered if medical necessity criteria are met.
If you are pregnant	Office visits	No Charge after deductible	No Charge after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge after deductible	No Charge after deductible	
	Childbirth/delivery facility services	No Charge after deductible	$2,000/visit plus plan deductible	
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	No Charge after deductible	Preauthorization may be required. 180-visit maximum per benefit period.
	Rehabilitation services	No Charge after deductible	No Charge after deductible	Preauthorization may be required. Includes physical, occupational and speech therapy.
	Habilitation services	No Charge after deductible	No Charge after deductible	
	Skilled nursing care	No Charge after deductible	No Charge after deductible	Preauthorization may be required. 60-day maximum per benefit period.
	Durable medical equipment	No Charge after deductible	No Charge after deductible	Preauthorization may be required.
	Hospice services	No Charge; deductible does not apply	Inpatient: $2,000/visit plus plan deductible Outpatient: No Charge after deductible	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	No Charge; deductible does not apply	One exam per benefit period for children under age 19.
	Children's glasses	No Charge after deductible	No Charge after deductible	One pair of glasses or one pair of contact lenses per benefit period for children under age 19.
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortion (except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed) • Bariatric surgery • Dental care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult) • Routine foot care (except when medically necessary) • Weight loss programs (with the exception of preventive services)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (12-visit maximum per benefit period) • Chiropractic care (10-visit maximum per benefit period)	• Cosmetic surgery (only for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases) • Hearing aids (for a covered child 18 years of age or younger, limited to 1 item per ear every 3 years or as required by a licensed audiologist)	• Infertility treatment (with the exception of in vitro fertilization and prescription medications)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-855-258-8471, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact your state insurance department at www.csi.mt.gov/industry/insurance.asp. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Montana at 1-855-258-8471, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform, or the Montana Commissioner of Securities and Insurance at 1-406-444-2040 or 1-800-332-6148. Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or visit www.csi.mt.gov.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-8471.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-8471.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-8471.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-8471.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

> ⚠️ **This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The **plan's** overall **deductible** $8,150	■ The **plan's** overall **deductible** $8,150	■ The **plan's** overall **deductible** $8,150
■ **Specialist** $0	■ **Specialist** $0	■ **Specialist** $0
■ **Hospital (facility)** $0	■ **Hospital (facility)** $0	■ **Hospital (facility)** $0
■ **Other** $0	■ **Other** $0	■ **Other** $0

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*	Primary care physician office visits *(including disease education)*	Emergency room care *(including medical supplies)*
Childbirth/Delivery Professional Services	Diagnostic tests *(blood work)*	Diagnostic test *(x-ray)*
Childbirth/Delivery Facility Services	Prescription drugs	Durable medical equipment *(crutches)*
Diagnostic tests *(ultrasounds and blood work)*	Durable medical equipment *(glucose meter)*	Rehabilitation services *(physical therapy)*
Specialist visit *(anesthesia)*		

Total Example Cost	$12,700	Total Example Cost	$5,600	Total Example Cost	$2,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$8,150
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,210**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,810**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 الرم 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. દ્ભાષિયા 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 आपके अपनी भाषा म निःशुल्क सहायता और जानकारी प्राप्त करन का अधिकार है। किसी अनवादक स बात करन क 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 شهافی، با شماره 855-710-6984 تمسا 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 لئے، 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.