

Individual Plan Comparison Chart

Participating In-Network Provider Coverage Shown¹

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 www.bcbsmt.com for more specific information.

Bronze	Blue Preferred Bronze PPO SM				Blue Focus Bronze POS SM	
	201 - Two \$25 PCP Visits	202	301	302*	205 - Two \$40 PCP Visits	302*
Individual Deductible ²	\$2,850	\$2,900	\$7,900	\$4,900	\$4,400	\$4,900
Coinsurance	50%	30%	0%	30%	50%	30%
Out-of-Pocket Maximum (includes deductible) ²	\$7,900	\$6,650	\$7,900	\$6,650	\$7,900	\$6,650
Primary Care Office Visit	First 2 visits \$25 copay, all other visits 50%	30%	0%	30%	First 2 visits \$40 copay, all other visits 50%	30%
Specialist Office Visit	50%	30%	0%	30%	50%	30%
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	50%	30%	0%	30%	50%	30%
Emergency Room	\$1,000 per occurrence deductible, then 50%	\$1,000 per occurrence deductible, then 30%	0%	\$1000 per occurrence deductible, then 30%	\$1,000 per occurrence deductible, then 50%	\$1000 per occurrence deductible, then 30%
Urgent Care	\$40 copay	30%	0%	30%	\$40 copay	30%
Inpatient Hospital Services	\$850 per occurrence deductible, then 50%	\$850 per occurrence deductible, then 30%	0%	\$850 per occurrence deductible, then 30%	\$850 per occurrence deductible, then 50%	\$850 per occurrence deductible, then 30%
Outpatient Surgery ³	\$600 per occurrence deductible, then 50%	\$600 per occurrence deductible, then 30%	0%	\$600 per occurrence deductible, then 30%	\$600 per occurrence deductible, then 50%	\$600 per occurrence deductible, then 30%
Outpatient X-Rays and Diagnostic Imaging ³	50%	30%	0%	30%	50%	30%
Outpatient Imaging (CT/PET Scans/MRIs) ³	50%	30%	0%	30%	50%	30%
Network	Blue Preferred PPO SM	Blue Preferred PPO SM	Blue Preferred PPO SM	Blue Preferred PPO SM	Blue Focus POS SM	Blue Focus POS SM
HSA Eligible ⁴	No	Yes	No	Yes	No	Yes
Outpatient Prescription Drugs - Value Pharmacy ^{5,6}	0%/10%/20%/35%/45%/50%	20%/25%/30%/35%/45%/50%	0% ⁷	20%/25%/30%/35%/45%/50%	0%/10%/20%/35%/45%/50%	20%/25%/30%/35%/45%/50%
Outpatient Prescription Drugs - Non-Value Pharmacy ^{5,6}	10%/20%/30%/40%/45%/50%	25%/30%/35%/40%/45%/50%	0% ⁷	25%/30%/35%/40%/45%/50%	10%/20%/30%/40%/45%/50%	25%/30%/35%/40%/45%/50%

Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through the Specialty Pharmacy provider.

Member Pay the Difference: When you choose a brand name drug over an available generic equivalent, you pay your usual share plus the difference in cost.

Prior Authorization/Step Therapy Requirements: Before you receive coverage for some medications, your doctor will 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 a 90-day supply of prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.

Prescription Drug Utilization Benefit Management Programs⁸

- Benefits are reduced when non-participating providers are used. This is a summary of benefit highlights only. All benefits shown indicate member responsibility.
- 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.
- 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.
- As a reminder, a Health Savings Account (HSA) has tax and legal ramifications. Blue Cross and Blue Shield of Montana does not provide legal or tax advice and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection

- with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax adviser regarding tax consequences of specific health insurance plans or products.
- Prescription benefit coverage starts after annual medical deductible has been met. Retail stores in the Value Pharmacy Network may offer members prescriptions with a lower possible copay amount.
- Prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.
- Prescription benefit coverage starts after annual deductible has been met. Once annual deductible is met, outpatient prescription drugs are covered at 100%.
- 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.

*** This plan is not available on the Health Insurance Marketplace in Montana.**