BlueCross BlueShield of Montana

Bozeman School District #7

Summary of Benefits

Blue Cross Group Medicare Advantage (PPO)[SM]

January 1, 2022 – December 31, 2022

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage Benefits Insert."

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INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

	Blue Cross Group Medicare Advantage (PPO)[SM]
You have choices about how to get your Medicare prescription drug benefits	• One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. • Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Group Medicare Advantage (PPO)**).
Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what **Blue Cross Group Medicare Advantage (PPO)** covers and what you pay. • If you want to compare our plans with other Medicare Health Plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov. • If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
Sections in this booklet	• Things to Know About **Blue Cross Group Medicare Advantage (PPO)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Prescription Drug Benefits
Hours of Operation	• From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. – 8:00 p.m. local time. • From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. – 8:00 p.m. local time.
Phone Numbers	• Call toll-free 1-877-299-1008. (TTY users should call 711).

	Blue Cross Group Medicare Advantage (PPO)[SM]
Who can join?	To join **Blue Cross Group Medicare Advantage (PPO)**, you must be enrolled in Part A and B, and be a retiree, or Medicare-eligible dependent of a retiree, of Bozeman School District #7. Our service area includes anywhere in the United States.
Which doctors, hospitals, and pharmacies can I use?	**Blue Cross Group Medicare Advantage (PPO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. • You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. • You can see our plan's *Provider Directory* and/or *Pharmacy Directory* at www.bcbsmt.com/retiree-medicare-tools.
What do we cover?	Like all Medicare health plans, we cover everything that Original Medicare covers—and *more*. **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less. **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the plan formulary (list of Part D prescription drugs) and any restrictions at www.bcbsmt.com/retiree-medicare-tools. Call us and we will send you a copy of the formulary.
How will I determine my drug costs?	Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, Coverage Gap, and Catastrophic Coverage.

SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

	Blue Cross Group Medicare Advantage (PPO)[SM]
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium?	For information concerning the actual premiums you will pay, please contact your employer or your employer group benefits plan administrator. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible for medical services.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. **Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.**
	Your yearly limit(s) in this plan: • $0 for services you receive from in-network providers. • $5,100 for services you receive from out-of-network providers. • $5,100 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain supplemental benefits. Contact us for the services that apply.

	Blue Cross Group Medicare Advantage (PPO)[SM]
COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: Services with a * may require prior authorization or a referral from your doctor.	
INPATIENT CARE	
Inpatient Hospital Care*	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $0 copay per stay • Out-of-network: 10% of the total cost per stay
OUTPATIENT CARE AND SERVICES	
Outpatient Hospital Care/ Surgery*	**Outpatient hospital** • In-network: $0 copay • Out-of-network: 10% of the total cost **Ambulatory surgical center** • In-network: $0 copay • Out-of-network: 10% of the total cost
Doctor's Office Visits*	**Primary care physician visit** • In-network: $0 copay • Out-of-network: 10% of the total cost **Specialist visit** • In-network: $0 copay • Out-of-network: 10% of the total cost

	Blue Cross Group Medicare Advantage (PPO)[SM]
Preventive Care*	• In-network: $0 copay • Out-of-network: 10% of the total cost
	Our plan covers many preventive services, including:
	• Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit **Any additional preventive services approved by Medicare during the contract year will be covered.**
Emergency Care	• In-network: $80 copay • Out-of-network: $80 copay See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services	• In-network: $40 copay • Out-of-network: $40 copay

	Blue Cross Group Medicare Advantage (PPO)[SM]
Diagnostic Tests, Lab and Radiology Services, and X-Rays*	**Diagnostic radiology services (such as MRIs, CT scans)** • In-network: $0 copay • Out-of-network: 10% of the total cost **Diagnostic tests and procedures** • In-network: $0 copay • Out-of-network: 10% of the total cost **Lab services** • In-network: $0 copay • Out-of-network: 10% of the total cost **Outpatient X-rays** • In-network: $0 copay • Out-of-network: 10% of the total cost **Therapeutic radiology services (such as radiation treatment for cancer)** • In-network: $0 copay • Out-of-network: 10% of the total cost
Hearing Services*	**Exam to diagnose and treat hearing and balance issues** • In-network: $0 copay • Out-of-network: 10% of the total cost **Routine hearing exam** • In-network: $0 copay for 1 routine hearing exam each year • Out-of-network: 10% of the total cost for 1 routine hearing exam each year **Hearing aids** • In-network and Out-of-network: $1,000 combined in-network and out-of-network allowance on hearing aids every 3 years

	Blue Cross Group Medicare Advantage (PPO)[SM]
Dental Services*	**<u>Medicare-covered limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)</u>** • In-network: 20% of the total cost • Out-of-network: 40% of the total cost **<u>Preventive dental services</u>** • In-network: $5 copay • Out-of-network: $5 copay (may balance bill above the network allowable charge) • In-network and Out-of-network: ◦ 2 cleanings each year ◦ 1 x-ray each year ◦ 2 oral exams each year **<u>Comprehensive dental services</u>** • In-network: $0 copay for Basic restorative: ex. cavities, non-surgical extractions, dental pain relief $0 copay for Major restorative: ex. Surgical tooth extractions, root canals; includes crowns and dentures • Out-of-network: Basic & Major restorative services covered the same as in-network except providers may balance bill above the in-network allowable charges. $1,000 combined in-network and out-of-network allowance on supplemental comprehensive dental services each year.

	Blue Cross Group Medicare Advantage (PPO)[SM]
Vision Services*	**Exam to diagnose and treat diseases and conditions of the eye** • In-network: $0 copay • Out-of-network: 40% of the total cost **Yearly glaucoma screening** • In-network: $0 copay • Out-of-network: 10% of the total cost **Eyeglasses or contact lenses after cataract surgery** • In-network: $40 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery • Out-of-network: 40% of the total cost for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery **Routine eye exam** • In-network: $10 copay for 1 routine eye exam each year • Out-of-network: $40 annual allowance for 1 routine eye exam each year **Routine eye wear** • $0 copay for standard eyeglass lenses • In-network and Out-of-network: $150 combined in-network and out-of-network allowance on routine eyewear every 2 years.

	Blue Cross Group Medicare Advantage (PPO)[SM]
Mental Health Care*	**Inpatient visit** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
	• In-network: $0 copay per stay • Out-of-network: 10% of the total cost per stay **Outpatient individual and group therapy visit with a mental health specialist** • In-network: $0 copay • Out-of-network: 10% of the total cost
Skilled Nursing Facility (SNF)*	**Our plan covers up to 100 days in a SNF.** • In-network: $0 copay per day for days 1-20 $0 copay per day for days 21-100 • Out-of-network: 10% of the total cost per day for days 1-20 10% of the total cost per day for days 21-100

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Outpatient Rehabilitation*	**Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions in 36 weeks)** • In-network: $0 copay • Out-of-network: 10% of the total cost **Occupational therapy visit** • In-network: $0 copay • Out-of-network: 10% of the total cost **Physical therapy and speech and language therapy visit** • In-network: $0 copay • Out-of-network: 10% of the total cost
Ambulance* ***(Medicare-covered ground and air transportation services)***	**Ground services** • In-network: $0 copay for each one-way trip • Out-of-network: $0 copay for each one-way trip **Air services** • In-network: $0 copay for each one-way trip • Out-of-network: $0 copay for each one-way trip
Transportation*	Not Covered
Medicare Part B Drugs*	**Part B chemotherapy drugs** • In-network: $0 copay • Out-of-network: 10% of the total cost **Other Part B drugs** • In-network: $0 copay • Out-of-network: 10% of the total cost

	Blue Cross Group Medicare Advantage (PPO)[SM]
PRESCRIPTION DRUG BENEFITS	
Stage 1: Part D Deductible	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you.
Stage 2: Initial Coverage	You pay the following (see table(s) below) until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Cost Shares During the Initial Coverage Stage

Initial Coverage Stage: Standard Retail Pharmacy	
Standard Retail	**Blue Cross Group Medicare Advantage (PPO)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 2: Generic	**One-month supply:** $11
	Three-month supply: $33
Tier 3: Preferred Brand	**One-month supply:** $44
	Three-month supply: $132
Tier 4: Non-Preferred Drug	**One-month supply:** $95
	Three-month supply: $285
Tier 5: Specialty Tier	**One-month supply:** 33%
	Three-month supply: 33%

Initial Coverage Stage: Preferred Retail Pharmacy	
Preferred Retail	**Blue Cross Group Medicare Advantage (PPO)℠**
Tier 1: Preferred Generic	**One-month supply:** $0
	Three-month supply: $0
Tier 2: Generic	**One-month supply:** $6
	Three-month supply: $18
Tier 3: Preferred Brand	**One-month supply:** $39
	Three-month supply: $117
Tier 4: Non-Preferred Drug	**One-month supply:** $85
	Three-month supply: $255
Tier 5: Specialty Tier	**One-month supply:** 33%
	Three-month supply: 33%

Initial Coverage Stage: Standard Mail Order Pharmacy	
Standard Mail Order	**Blue Cross Group Medicare Advantage (PPO)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 2: Generic	**One-month supply:** $11
	Three-month supply: $33
Tier 3: Preferred Brand	**One-month supply:** $44
	Three-month supply: $132
Tier 4: Non-Preferred Drug	**One-month supply:** $95
	Three-month supply: $285
Tier 5: Specialty Tier	**One-month supply:** 33%
	Three-month supply: 33%

Initial Coverage Stage: Preferred Mail Order Pharmacy	
Preferred Mail Order	**Blue Cross Group Medicare Advantage (PPO)℠**
Tier 1: Preferred Generic	**One-month supply:** $0
	Three-month supply: $0
Tier 2: Generic	**One-month supply:** $6
	Three-month supply: $18
Tier 3: Preferred Brand	**One-month supply:** $39
	Three-month supply: $117
Tier 4: Non-Preferred Drug	**One-month supply:** $85
	Three-month supply: $255
Tier 5: Specialty Tier	**One-month supply:** 33%
	Three-month supply: 33%

Initial Coverage Stage: Long-term Care and Out-of-network Pharmacies (one-month supply)	
	Blue Cross Group Medicare Advantage (PPO)[SM]
Long-term Care Tiers 1-5	If you reside in a long-term facility, you pay the same as at a retail pharmacy.
Out-of-network Tiers 1-5	You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You generally must use a network pharmacy to fill your prescription.

	Blue Cross Group Medicare Advantage (PPO)[SM]
Stage 3: Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. See the table(s) below for your costs during this stage. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $7,050.

Coverage Gap Stage: Standard Retail Pharmacy	
Standard Retail	**Blue Cross Group Medicare Advantage (PPO)℠**
Tier 1: Preferred Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 2: Generic	**One-month supply:** $11
	Three-month supply: $33
Tier 3: Preferred Brand	**One-month supply:** $44
	Three-month supply: $132
Tier 4: Non-Preferred Drug	**One-month supply:** $95
	Three-month supply: $285
Tier 5: Specialty Tier	**One-month supply:** 15%
	Three-month supply: 15%

Coverage Gap Stage: Preferred Retail Pharmacy	
Preferred Retail	**Blue Cross Group Medicare Advantage (PPO)℠**
Tier 1: Preferred Generic	**One-month supply:** $0
	Three-month supply: $0
Tier 2: Generic	**One-month supply:** $6
	Three-month supply: $18
Tier 3: Preferred Brand	**One-month supply:** $39
	Three-month supply: $117
Tier 4: Non-Preferred Drug	**One-month supply:** $85
	Three-month supply: $255
Tier 5: Specialty Tier	**One-month supply:** 15%
	Three-month supply: 15%

Coverage Gap Stage: Standard Mail Order Pharmacy	
Standard Mail Order	**Blue Cross Group Medicare Advantage (PPO)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 2: Generic	**One-month supply:** $11
	Three-month supply: $33
Tier 3: Preferred Brand	**One-month supply:** $44
	Three-month supply: $132
Tier 4: Non-Preferred Drug	**One-month supply:** $95
	Three-month supply: $285
Tier 5: Specialty Tier	**One-month supply:** 15%
	Three-month supply: 15%

Coverage Gap Stage: Preferred Mail Order Pharmacy	
Preferred Mail Order	**Blue Cross Group Medicare Advantage (PPO)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $0
	Three-month supply: $0
Tier 2: Generic	**One-month supply:** $6
	Three-month supply: $18
Tier 3: Preferred Brand	**One-month supply:** $39
	Three-month supply: $117
Tier 4: Non-Preferred Drug	**One-month supply:** $85
	Three-month supply: $255
Tier 5: Specialty Tier	**One-month supply:** 15%
	Three-month supply: 15%

	Blue Cross Group Medicare Advantage (PPO)[SM]
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $7,050, you pay the greater of: • 5% of the total cost, or • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs

	Blue Cross Group Medicare Advantage (PPO)[SM]
ADDITIONAL MEMBER BENEFITS	
NOTE: Services with a * may require prior authorization or a referral from your doctor.	
Acupuncture	**<u>Acupuncture for chronic low back pain (Medicare-covered)</u>** • In-network: $0 copay • Out-of-network: $0 copay **<u>Acupuncture (non-Medicare-covered)</u>** Not Covered
Chiropractic Care*	**<u>Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)</u>** • In-network: $0 copay • Out-of-network: 10% of the total cost
Diabetes Supplies and Services*	**<u>Diabetes monitoring supplies</u>** • In-network: Medicare-covered diabetic supplies: 0% of the total cost (0% for preferred test strips; 20% for all other supplies) • Out-of-network: 10% of the total cost (10% for preferred test strips; 20% for all other supplies) **<u>Diabetes self-management training</u>** • In-network: $0 copay • Out-of-network: 10% of the total cost
Durable Medical Equipment *(wheelchairs, oxygen, etc.)**	• In-network: $0 copay • Out-of-network: 10% of the total cost

	Blue Cross Group Medicare Advantage (PPO)[SM]
Wellness Programs	$0 copay for SilverSneakers®† Fitness Program This benefit includes SilverSneakers instructor-led group fitness classes. At participating locations, you can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms. SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and a mobile app, SilverSneakers GO™. †SilverSneakers, SilverSneakers FLEX, SilverSneakers On-Demand, and SilverSneakers GO are registered trademarks or trademarks of Tivity Health, Inc.
Foot Care *(podiatry services)**	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** • In-network: $0 copay • Out-of-network: 10% of the total cost
Home Health Care*	• In-network: $0 copay • Out-of-network: $0 copay
Opioid Treatment Program Services*	• In-network: $0 copay • Out-of-network: $0 copay
Outpatient Substance Abuse Services*	**Group therapy visit** • In-network: $0 copay • Out-of-network: 10% of the total cost **Individual therapy visit** • In-network: $0 copay • Out-of-network: 10% of the total cost
Over-the-Counter Items	• $20 allowance every month for specific over-the-counter drugs and other health-related products. Unused monthly allowance will rollover to the next month but does not rollover to the next year.

	Blue Cross Group Medicare Advantage (PPO)[SM]
Prosthetic Devices *(braces, artificial limbs, etc.)**	**Prosthetic devices** • In-network: $0 copay • Out-of-network: 10% of the total cost **Related medical supplies** • In-network: $0 copay • Out-of-network: 10% of the total cost
Meals	Not Covered
Renal Dialysis*	• In-network: $0 copay • Out-of-network: 10% of the total cost
Supplemental Telehealth Services	• In-network: $25 copay for urgent care; $0 copay for Outpatient Mental Health; $0 copay for Outpatient Mental Health Psychiatric visit through MDLive.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

BlueCross BlueShield of Montana

Blue Cross and Blue Shield of Montana complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Montana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Montana:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Montana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-299-1008** (TTY/TDD: **711**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-299-1008** (TTY/TDD: **711**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-299-1008** (TTY/TDD: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-299-1008**（TTY/TDD：**711**）。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-299-1008**（TTY/TDD: **711**）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-299-1008** (TTY/TDD: **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-299-1008** (ATS : **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-299-1008** (телетайп: **711**).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-299-1008** (TTY/TDD: **711**) 번으로 전화해 주십시오

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-299-1008** (رقم هاتف الصم والبكم: **711**).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-299-1008** (TTY/TDD: **711**).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring **1-877-299-1008** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-299-1008** (TTY/TDD: **711**).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-877-299-1008** (телетайп: **711**).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call **1-877-299-1008** (TTY: **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-299-1008** (TTY/TDD: **711**).

BlueCross BlueShield of Montana

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-877-299-1008 (TTY: 711) for more information.

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.