




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) 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, call 1-855-258-3489 or visit www.bcbsmt.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$1,100 Individual / \$2,200 Family In-Network \$5,000 Individual / \$10,000 Family Out-of-Network	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. Well-child and <u>In-Network preventive health</u> , <u>prescription drugs</u> , and services that charge a <u>copay</u> 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 plan covers certain <u>preventive</u> services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$2,200 Individual / \$4,400 Family In-Network \$6,000 Individual / \$12,000 Family Out-of-Network	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-billed</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 or call 1-855-258-3489 for a list of participating <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 referral.

 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
		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	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual visits are available through MDLive. Refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. <u>Deductible</u> does not apply to the first \$70 for routine mammograms Out-of-Network.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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/rx .	Preferred generic drugs	Value Retail: \$0 <u>copay</u> Participating Retail: \$5 <u>copay</u> Mail: \$0 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$5 <u>copay</u> ; <u>deductible</u> does not apply	Lower <u>copayment</u> applies at Value pharmacies. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription at a <u>plan</u> approved mail order pharmacy); 90-day supply (retail extended supply network pharmacy). Extended Supply Network <u>copayments</u> are three times retail <u>copayments</u> . <u>Specialty drugs</u> covered up to a 30-day supply. Mail order is not covered.
	Non-preferred generic drugs	Value Retail: \$10 <u>copay</u> Participating Retail: \$15 <u>copay</u> Mail: \$20 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$15 <u>copay</u> ; <u>deductible</u> does not apply	
	Preferred brand drugs	Value Retail: \$50 <u>copay</u> Participating Retail: \$60 <u>copay</u> Mail: \$100 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$60 <u>copay</u> ; <u>deductible</u> does not apply	
	Non-preferred brand drugs	Value Retail: \$100 <u>copay</u> Participating Retail: \$110 <u>copay</u> Mail: \$200 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$110 <u>copay</u> ; <u>deductible</u> does not apply	
	<u>Specialty drugs</u>	\$150 <u>copay</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your member guide* for details.
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	In network accident injury care is No Charge, deductible waived, for the first \$300 charges.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your member guide* for details.
	<u>Urgent care</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual visits are available through MDLive. Refer to your <u>plan</u> policy for more details. Outpatient: <u>Preauthorization</u> may be required; see your member guide* for details. Inpatient: <u>Preauthorization</u> required. Residential treatment facilities will be covered if medical necessity criteria are met.
	Inpatient services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Office visits	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. 180 visit maximum per benefit period.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Chiropractic care processes at <u>In Network</u> benefit level, regardless of <u>provider</u> status. <u>Preauthorization</u> may be required. 35-visit maximum per benefit period for chiropractic care
	<u>Habilitation services</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. No applied behavior analysis (ABA) benefits for autism spectrum disorder available for members 19 years of age or older.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. 60 days maximum per benefit period.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	<u>Preauthorization</u> may be required.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Benefit for exam: \$100 maximum per benefit period. Limited to 1 exam per benefit period.
	Children's glasses	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Benefit for frames, lenses and contacts: \$150 maximum per benefit period.
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (6 visit maximum per benefit period)
- Chiropractic care (35 visit maximum per benefit period)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Private-duty nursing
- Weight loss programs (physician-led weight management programs are covered if pre-approved by the plan)

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

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 1-855-258-3489 U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 1-855-258-3489 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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 1-855-258-3489.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-3489.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-258-3489.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-3489.

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)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,100
■ <u>Specialist</u> coinsurance	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost sharing</i>	
Deductibles	\$1,100
Copayments	\$30
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,290

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,100
■ <u>Specialist</u> coinsurance	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost sharing</i>	
Deductibles	\$1,100
Copayments	\$900
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,160

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,100
■ <u>Specialist</u> coinsurance	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost sharing</i>	
Deductibles	\$1,100
Copayments	\$0
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,180

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 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
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

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
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>