



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 1-800-447-7828 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 deductible?	\$2,000 person / \$4,000 family In-Network \$4,000 person / \$8,000 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 deductible?	Yes. Services with a <u>copay</u> , <u>prescription drugs</u> , home health, hospice, well-child, and In-Network diagnostic mammograms and preventive health 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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$4,000 person / \$8,000 family In-Network \$8000 person / \$16,000 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 out-of-pocket limit?	<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 network provider?	Yes. See www.bcbsmt.com or call 1-800-447-7828 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 referral to see a specialist?	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
		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	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Virtual Visit: \$25/visit. See your member guide* for details.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Maximum of one electric breast pump per year. <u>Deductible</u> and <u>coinsurance</u> do not apply to the first \$70 for Out-of-Network routine mammograms. <u>Deductible</u> does not apply to Out-of-Network well child service. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsmt.com/member/prescription-drug-plan-information/drug-lists	Preferred generic drugs	Value Retail: \$0 <u>copay</u> Participating Retail: \$10 <u>copay</u> Mail: \$0 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$10 <u>copay</u> ; <u>deductible</u> does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at an approved mail order pharmacy. <u>Specialty drugs</u> limited to a 30-day supply Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. The difference will not apply to any <u>deductible</u> or out-of-pocket amounts. All Out-of-Network prescriptions are subject to a 50% benefit reduction after the applicable <u>copay/coinsurance</u> . The benefit reduction will not apply to any <u>deductible</u> or out-of-pocket amounts.
	Non-preferred generic drugs	Value Retail: \$10 <u>copay</u> Participating Retail: \$20 <u>copay</u> Mail: \$30 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$20 <u>copay</u> ; <u>deductible</u> does not apply	
	Preferred brand drugs	Value Retail: \$50 <u>copay</u> Participating Retail: \$70 <u>copay</u> Mail: \$150 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$70 <u>copay</u> ; <u>deductible</u> does not apply	
	Non-preferred brand drugs	Value Retail: \$100 <u>copay</u> Participating Retail: \$120 <u>copay</u> Mail: \$300 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$120 <u>copay</u> ; <u>deductible</u> does not apply	
	Preferred <u>specialty drugs</u>	\$150 <u>copay</u> ; <u>deductible</u> does not apply	\$150 <u>copay</u> ; <u>deductible</u> does not apply	
	Non-preferred <u>specialty drugs</u>	\$250 <u>copay</u> ; <u>deductible</u> does not apply	\$250 <u>copay</u> ; <u>deductible</u> does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your member guide* for details. For Outpatient Infusion Therapy see your member guide* for details.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your member guide* for details.
	<u>Urgent care</u>	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Outpatient: <u>Preauthorization</u> may be required; see your member guide* for details. Inpatient: <u>Preauthorization</u> required.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Residential treatment facilities will be covered if medical necessity criteria are met.
If you are pregnant	Office visits	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. 180-visit maximum per benefit period.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <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>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. 60 days maximum per benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<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.

* 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 your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	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 (except for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (except for persons with co-morbidities, such as diabetes)
- Weight loss programs

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)
- Infertility treatment (with the exception of in vitro fertilization and prescription medications)
- Non-emergency care when traveling outside the U.S.

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 1-800-447-7828 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 1-800-447-7828 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 1-800-447-7828.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-447-7828.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-447-7828.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-447-7828.

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>	\$2,000
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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	\$2,000
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

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>	\$2,000
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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	\$1,900
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,160

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

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>