




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, visit [www.bcbsmt.com](http://www.bcbsmt.com) or by calling 1-888-901-4989. 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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>In-Network</u> : \$1,000 Individual <u>Out-of-Network</u> : \$1,500 Individual	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Services with a <u>copayment</u> 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 <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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<u>Medical In-Network</u> : \$4,000 Individual / \$8,000 Family <u>Medical Out-of-Network</u> : \$4,950 Individual / \$10,900 Family <u>Pharmacy</u> : \$1,800 Individual / \$3,600 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <u>balance-billed</u> charges and health care this <u>plan</u> doesn't cover. Non-Preferred (Tier 3) brand and Non-Preferred specialty (Tier 4) products do not accrue towards the pharmacy <u>out-of-pocket maximum</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.bcbsmt.com">www.bcbsmt.com</a> or call 1-888-901-4989 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	<u>Copayment</u> applies only for evaluation and management. Additional charges are subject to <u>deductible</u> and <u>coinsurance</u> .
	<u>Specialist</u> visit	\$35/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	<u>Copayment</u> applies only for evaluation and management. Additional charges are subject to <u>deductible</u> and <u>coinsurance</u> .
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	35% <u>coinsurance</u>	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)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Recommended Clinical Review; see your <u>plan</u> document* for details.
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Recommended Clinical Review; see your <u>plan</u> document* for details.

\* For more information about limitations and exceptions, see the plan or policy document at [benefits.mt.gov](https://benefits.mt.gov)

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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://benefits.mt.gov">benefits.mt.gov</a> or call 1-866-333-2757 for Commercial members or 1-866-270-3877 for Medicare RX members.</p>	\$0 Preventive products	No Charge (certain preventive care and select medications).	No Charge (certain preventive care and select medications), limited to a 10 day supply.	Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program, Navitus.
	Tier 1 Preferred generics and some lower cost brand products	\$15 copayment retail 1-34 day supply, \$30 copayment retail 35-90 day supply, \$30 copayment mail order up to 90 day supply.	\$15 copayment retail, limited to a 10 day supply.	If generic is available and chosen over brand, regardless of how prescription is written, member is responsible for the difference in cost plus applicable brand copayment.
	Tier 2 Preferred brand products and some high cost non-preferred generics	\$50 copayment retail 1-34 day supply, \$100 copayment retail 35-90 day supply, \$100 copayment mail order up to 90 day supply.	\$50 copayment retail, limited to a 10 day supply.	Fills provided by a non-preferred pharmacy are limited to 10 day supply.  Certain prescriptions require prior approval before the drug can be authorized for coverage.
	Tier 3 Non-preferred products (may include some high cost non-preferred generics)	50% coinsurance retail or mail order up to 90 day supply.	50% coinsurance retail, limited to a 10 day supply.	Tier 3 Non-Preferred brand prescriptions do not accrue towards the pharmacy out-of-pocket maximum.
	Tier 4 Specialty products	\$200 copayment Preferred Specialty Pharmacy.	50% coinsurance Non-Preferred Specialty Pharmacy or retail.	Specialty prescriptions should be obtained from a specialty pharmacy. Specialty prescriptions are limited to a 34 day supply. Non-Preferred Specialty prescriptions do not accrue toward the pharmacy out-of-pocket maximum. A \$50 copayment will apply to Preferred Specialty Pharmacy products for Medicare retirees only.

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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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Recommended Clinical Review; see your <u>plan document*</u> for details.
	Physician/surgeon fees	25% <u>coinsurance</u>	35% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: 25% <u>coinsurance</u> ER Physician Charges: 25% <u>coinsurance</u>	Facility Charges: 25% <u>coinsurance</u> ER Physician Charges: 25% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Recommended Clinical Review; see your <u>plan document*</u> for details.
	<u>Urgent care</u>	\$35/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	Ancillary charges are subject to <u>deductible</u> and <u>coinsurance</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Recommended Clinical Review.
	Physician/surgeon fees	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25/office visit; <u>deductible</u> does not apply 25% <u>coinsurance</u> for other outpatient services	35% <u>coinsurance</u>	Recommended Clinical Review; see your <u>plan document*</u> for details.
	Inpatient services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Recommended Clinical Review. Residential treatment facilities will be covered if medical necessity criteria are met.
If you are pregnant	Office visits	\$25 Primary Care/ \$35 Specialist; <u>deductible</u> does not apply	35% <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). Recommended Clinical Review.
	Childbirth/delivery professional services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	

\* For more information about limitations and exceptions, see the plan or policy document at [benefits.mt.gov](https://benefits.mt.gov)

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Recommended Clinical Review. 70 visit maximum per benefit period.
	<u>Rehabilitation services</u>	\$25/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	Recommended Clinical Review. <u>Deductible</u> and <u>coinsurance</u> apply to other therapy services.
	<u>Habilitation services</u>	\$25/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Recommended Clinical Review. 70 days maximum per benefit period.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Recommended Clinical Review for items \$2,500 and over.
	<u>Hospice services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Recommended Clinical Review. Includes bereavement counseling.
<b>If your child needs dental or eye care</b>	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:**

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b>		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery (except for correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (diagnosis of infertility covered)</li> <li>• Long term care</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care (except for individuals with co-morbidities, such as diabetes)</li> <li>• Weight loss programs (except preventive services)</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (20 visit maximum combined with Chiropractic per benefit period)</li> <li>• Chiropractic care (20 visit maximum combined with Acupuncture per benefit period)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (for dependent children under age 19, and <u>medically necessary</u> cochlear implants, per medical policy)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [benefits.mt.gov](http://benefits.mt.gov)

**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 1-888-901-4989, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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 on how 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 1-888-901-4898, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://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](http://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? 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 1-888-901-4989.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4989.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-901-4989.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-901-4989.

*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 plan's overall deductible	\$1,000
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$2,900
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,000</b>

### Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,020</b>

### Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>



<b>Health care coverage is important for everyone.</b>	
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. 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. 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., 35 <sup>th</sup> Floor Chicago, IL 60601	Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960
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: <a href="https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf">https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf</a> Complaint Forms: <a href="https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html">https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html</a>

<b>To receive language or communication assistance free of charge, please call us at 855-710-6984.</b>	
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinit's'ágóó, shá ata' hodooni nínízingo, t'áájíik'eh bee náhaz'á. 1-866-560-4042 jí' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.