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 by calling 1-855-258-3489 or at 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.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $3,000 Individual / $6,000 Family Out-of-Network: $6,000 Individual / $12,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services with a copayment, prescription drugs, well-child and In-Network diagnostic mammograms and preventive health are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $6,350 Individual / $12,700 Family Out-of-Network: $12,700 Individual / $25,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsmt.com or call 1-855-258-3489 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist 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	$35 copayment/visit; deductible does not apply	45% coinsurance	Virtual visit: No Charge; deductible does not apply. See your member guide* for details.
	Specialist visit	$35 copayment/visit; deductible does not apply	45% coinsurance	None
	Preventive care/screening/ Immunization	No Charge; deductible does not apply	45% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	45% coinsurance	Preauthorization may be required; see your member guide* for details. First $500 covered in full and is shared between all Diagnostic, X-ray, Lab, and Imaging services.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	45% coinsurance	Preauthorization may be required; see your member guide* for details. First $500 covered in full and is shared between all Diagnostic, X-ray, Lab, and Imaging services.

* 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 https://www.bcbsmt.com/member/prescription-drug-plan-information/drug-lists.	Preferred generic drugs	Retail: $10 copayment Mail: $20 copayment; deductible does not apply	$10 copayment plus 40% coinsurance (retail); deductible does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at an approved mail order pharmacy. Specialty drugs 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 deductible or out-of-pocket amounts. Out-of-Network mail order is not covered. SaveonSP affects your cost share for certain drugs. See Member Guide* for details. A covered insulin drug will not exceed $35 copayment for a 30-day supply.
	Non-preferred generic drugs	30% up to a maximum of $250/prescription; deductible does not apply	30% up to a maximum of $250/prescription plus 40% coinsurance (retail); deductible does not apply	
	Preferred brand drugs	Retail: $30 copayment Mail: $60 copayment; deductible does not apply	$30 copayment plus 40% coinsurance (retail); deductible does not apply	
	Non-preferred brand drugs	Retail: 30% up to a maximum of $250/prescription; deductible does not apply Mail: 30% up to a maximum of $500/prescription; deductible does not apply	30% up to a maximum of $250/prescription plus 40% coinsurance (retail); deductible does not apply	
	Preferred specialty drugs	$50/prescription; deductible does not apply	Not Covered	
	Non-preferred specialty drugs	30% up to a maximum of $250/prescription; deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	45% coinsurance	Preauthorization may be required; see your member guide* for details.
	Physician/surgeon fees	30% coinsurance	45% coinsurance	

* 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 immediate medical attention	Emergency room care	Facility Charges: $250 copayment/visit; deductible does not apply ER Physician Charges: No Charge; deductible does not apply	Facility Charges: $250 copayment/visit; deductible does not apply ER Physician Charges: No Charge; deductible does not apply	Copayment waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Preauthorization may be required for non-emergency transportation; see your member guide* for details.
	Urgent care	$35 copayment/visit; deductible does not apply	45% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	45% coinsurance	Preauthorization required.
	Physician/surgeon fees	30% coinsurance	45% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	45% coinsurance	Preauthorization may be required; see your member guide* for details. For Outpatient Services provided in the office Please refer to "If you visit a health care provider's office or clinic".
	Inpatient services	30% coinsurance	45% coinsurance	Preauthorization required. Residential treatment facilities will be covered if medical necessity criteria are met.
If you are pregnant	Office visits	$35 copayment/visit; deductible does not apply	45% coinsurance	Copayment applies to first prenatal visit (per pregnancy) when global billing applies. Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization may be required.
	Childbirth/delivery professional services	30% coinsurance	45% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	45% coinsurance	

* 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 help recovering or have other special health needs	Home health care	30% coinsurance	45% coinsurance	Preauthorization may be required. 130 visit maximum per benefit period.
	Rehabilitation services	$35 copayment/visit; deductible does not apply	45% coinsurance	Preauthorization may be required. Outpatient: Combined 45 visit limits per benefit period for physical, speech, and occupational therapies. Inpatient: Limited to combined 30 days limit per benefit period. For Inpatient Services Please refer to "If you have a hospital stay".
	Habilitation services	$35 copayment/visit; deductible does not apply	45% coinsurance	
	Skilled nursing care	30% coinsurance	45% coinsurance	Preauthorization may be required. 60 days maximum per benefit period.
	Durable medical equipment	30% coinsurance	45% coinsurance	Preauthorization may be required.
	Hospice services	30% coinsurance	45% coinsurance	Preauthorization may be required. 180 days maximum per benefit period.
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 (except for dependent children under age 19, and medically necessary cochlear implants, per medical policy)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (except for individuals with co-morbidities, such as diabetes)
- Weight loss programs (except preventive services)

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 (24 visit maximum per benefit period)
- Non-emergency care when traveling outside the U.S.

* 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 (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

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 1-855-258-3489.

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, kwiijigo 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 plan's overall deductible	$3,000
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$50
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,010**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Montana

Health care coverage is important for everyone.

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., 35th 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: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، 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 કૉલ 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 dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' 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.