




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 1-855-322-4953 or visit [www.MUSTbenefits.org](http://www.MUSTbenefits.org). 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 deductible?</b>                             | \$6,000 Individual / \$12,000 Family   | 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> .   |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Diabetic education, initial accident care, breast pumps, mammograms, and <u>preventive</u> health & well-child 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 deductibles for specific services?</b>          | No.  | You don't have to meet <u>deductibles</u> for specific services.  |
| <b>What is the out-of-pocket limit for this plan?</b>              | \$6,000 Individual / \$12,000 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 out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</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> .  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.bcbsmt.com">www.bcbsmt.com</a> or call 1-855-322-4953 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 charge</u> 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 referral to see a specialist?</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   |
|--|--|---|--|--|
|  |  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | Virtual visits available through MDLIVE: No Charge after <u>deductible</u> .   |
|  | <u>Specialist</u> visit                          | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | None   |
|  | <u>Preventive care/screening/immunization</u>    | No Charge; <u>deductible</u> does not apply     | No Charge after <u>deductible</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. Coverage for a pap test limited to 1 per <u>plan</u> year. Coverage for colonoscopy limited to 1 every 10 years beginning at age 50. |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)       | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | None   |
|  | Imaging (CT/PET scans, MRIs)                     | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | None   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.MUSTbenefits.org">www.MUSTbenefits.org</a> | Preferred generic drugs                          | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | 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 <u>network</u> pharmacy).   |
|  | Non-preferred generic drugs                      | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  |  |
|  | Preferred brand drugs                            | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  |  |
|  | Non-preferred brand drugs                        | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  |  |
|  | <u>Preferred specialty drugs</u>                 | Not Covered                                     | Not Covered  |  |
|  | <u>Non-preferred specialty drugs</u>             | Not Covered                                     | Not Covered  |  |

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

| Common Medical Event  | Services You May Need                          | What You Will Pay                               |  | Limitations, Exceptions, & Other Important Information  |
|---|--|---|--|---|
|   |  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center) | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | <u>Preauthorization</u> required.   |
|   | Physician/surgeon fees                         | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | None  |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | The <u>plan</u> pays the first \$500 of eligible expenses for accident injuries; <u>deductible</u> waived.  |
|   | <u>Emergency medical transportation</u>        | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | None  |
|   | <u>Urgent care</u>                             | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | None  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)             | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | <u>Preauthorization</u> required.   |
|   | Physician/surgeon fees                         | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | None  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | Virtual visits available through MDLIVE: No Charge after <u>deductible</u> .  |
|   | Inpatient services                             | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | <u>Preauthorization</u> required.   |
| If you are pregnant   | Office visits                                  | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services      | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  |   |
|   | Childbirth/delivery facility services          | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | <u>Preauthorization</u> required.   |

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

| Common Medical Event  | Services You May Need            | What You Will Pay                               |  | Limitations, Exceptions, & Other Important Information   |
|---|----------------------------------|---|--|--|
|   |                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | 180-day combined maximum for <u>home health care</u> and <u>hospice</u> . <u>Preauthorization</u> required.  |
|   | <u>Rehabilitation services</u>   | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | Outpatient physical, occupational, speech, and cardiac therapies have a combined 50-visit maximum per benefit period. Inpatient physical, occupational, speech, and cardiac therapies have a combined 60-day maximum per benefit period. <u>Preauthorization</u> required for inpatient therapies. |
|   | <u>Habilitation services</u>     | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | None   |
|   | <u>Skilled nursing care</u>      | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | 60 days maximum per benefit period. <u>Preauthorization</u> required.  |
|   | <u>Durable medical equipment</u> | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | None   |
|   | <u>Hospice services</u>          | No Charge after <u>deductible</u>               | No Charge after <u>deductible</u>                  | 180-day combined maximum for <u>home health care</u> and <u>hospice</u> . <u>Preauthorization</u> required.  |
| <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   |

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

## 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)
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Acupuncture (10 visits combined with Chiropractic care)
- Chiropractic care (10 visits combined with Acupuncture)
- Hearing aids (for dependent children under age 19, and medically necessary cochlear implants, per medical policy)
- Most coverage provided outside the United States. See [www.bcbsmt.com](http://www.bcbsmt.com).
- Weight loss programs

**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 1-855-322-4953, 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 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 1-855-322-4953 or visit [www.bcbsmt.com](http://www.bcbsmt.com), or contact 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). Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or [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 1-855-322-4953.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-322-4953.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-322-4953.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-322-4953.

*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> | \$6,000 |
| ■ <u>Specialist</u> coinsurance               | 0%      |
| ■ Hospital (facility) <u>coinsurance</u>      | 0%      |
| ■ Other <u>coinsurance</u>                    | 0%      |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$6,000        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$6,060</b> |

### 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> | \$6,000 |
| ■ <u>Specialist</u> coinsurance               | 0%      |
| ■ Hospital (facility) <u>coinsurance</u>      | 0%      |
| ■ Other <u>coinsurance</u>                    | 0%      |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$5,400        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$5,420</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$6,000 |
| ■ <u>Specialist</u> coinsurance               | 0%      |
| ■ Hospital (facility) <u>coinsurance</u>      | 0%      |
| ■ Other <u>coinsurance</u>                    | 0%      |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |



**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, sexual orientation, health status 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

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>



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.

|                          |  |
|--------------------------|--|
| Español<br>Spanish       | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.                               |
| العربية<br>Arabic        | إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل بلع الرقم 855-710-6984.   |
| 繁體中文<br>Chinese          | 如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。   |
| Français<br>French       | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.           |
| Deutsch<br>German        | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.   |
| ગુજરાતી<br>Gujarati      | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્ન હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો. |
| हिंदी<br>Hindi           | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनवादक से बात करने के लिए 855-710-6984 पर कॉल करें।                                 |
| Italiano<br>Italian      | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.                         |
| 한국어<br>Korean            | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.  |
| Diné<br>Navajo           | T'áá ní, éi doodago la'da biká anánílwo'ígíí, na'ídiilkidgo, ts'ídá bee ná ahóótí'í t'áá níik'e níká a'doolwoł dóó bina'ídiilkidigíí bee ní h odoonih. Ata'dahalne'ígíí bich'í'í hodiilnih kwe'é 855-710-6984.                 |
| فارسی<br>Persian         | اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.                   |
| Polski<br>Polish         | Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.                     |
| Русский<br>Russian       | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.      |
| Tagalog<br>Tagalog       | Kung ikaw, o ang isang taong iyong tinutulongan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.  |
| اردو<br>Urdu             | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔                                  |
| Tiếng Việt<br>Vietnamese | Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.                             |