




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. 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/ccio/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?	\$500 person / \$1,000 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. Prescription drugs, services that charge a copay, initial accident care, chiropractic care, diabetic education, acupuncture, travel benefit, breast pumps, mammograms, and preventive health and well-child 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?	\$1,500 person / \$3,000 family Prescription drug limit: \$1,650 person / \$3,300 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-billed 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 1-855-322-4953 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
		In-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	20% <u>coinsurance</u>	Virtual visits available through MDLIVE: \$25 <u>copay</u> ; <u>deductible</u> does not apply.
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	20% <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. 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MUSTbenefits.org	Preferred generic drugs	Retail: \$10 <u>copay</u> Mail: \$20 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$10 <u>copay</u> ; <u>deductible</u> does not apply	<u>Prescription drug out-of-pocket limit</u> : \$1,650 person / \$3,300 family 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). <u>Specialty drugs</u> covered up to a 30-day supply. Extended Supply Network <u>copayments</u> are two times retail <u>copayments</u> .
	Non-preferred generic drugs	Retail: \$30 <u>copay</u> Mail: \$60 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$30 <u>copay</u> ; <u>deductible</u> does not apply	
	Preferred brand drugs	Retail: \$50 <u>copay</u> Mail: \$100 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$50 <u>copay</u> ; <u>deductible</u> does not apply	
	Non-preferred brand drugs	Retail: \$150 <u>copay</u> Mail: \$300 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$150 <u>copay</u> ; <u>deductible</u> does not apply	
	Preferred <u>specialty drugs</u>	Retail: \$150 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$150 <u>copay</u> ; <u>deductible</u> does not apply	
	Non-preferred <u>specialty drugs</u>	Retail: \$300 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$300 <u>copay</u> ; <u>deductible</u> does not apply	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	The <u>plan</u> pays the first \$500 of eligible expenses for accident injuries; <u>deductible</u> and <u>coinsurance</u> waived.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <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	20% <u>coinsurance</u>	First 3 visits per <u>plan</u> year not subject to <u>deductible</u> and <u>coinsurance</u> . Subsequent visits \$25 <u>copay</u> per visit.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required.
If you are pregnant	Office visits	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive</u> services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	180-day combined maximum for <u>home health care</u> and <u>hospice</u> . <u>Preauthorization</u> required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</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>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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>	20% <u>coinsurance</u>	60 days maximum per benefit period. <u>Preauthorization</u> required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	180-day combined maximum for <u>home health care</u> and <u>hospice</u> . <u>Preauthorization</u> 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	Limited to 1 exam per benefit <u>plan</u> year.
	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.

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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- Acupuncture
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbsmt.com.
- Routine eye care (Adult)
- 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](http://www.dol.gov/ebsa/healthreform) 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, 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](http://www.HealthCare.gov). For more information about the [Marketplace](http://www.HealthCare.gov), 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](http://www.bcbsmt.com) for a denial of a [claim](http://www.bcbsmt.com). This complaint is called a [grievance](http://www.bcbsmt.com) or [appeal](http://www.bcbsmt.com). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](http://www.bcbsmt.com). Your [plan](http://www.bcbsmt.com) documents also provide complete information to submit a [claim](http://www.bcbsmt.com), [appeal](http://www.bcbsmt.com), or a [grievance](http://www.bcbsmt.com) for any reason to your [plan](http://www.bcbsmt.com). 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, 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. Additionally, a consumer assistance program can help you file your [appeal](http://www.csi.mt.gov). Contact the Montana Consumer Assistance Program at 1-800-332-6148 or www.csi.mt.gov.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](http://www.bcbsmt.com) 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](http://www.bcbsmt.com) doesn't meet the [Minimum Value Standards](http://www.bcbsmt.com), you may be eligible for a [premium tax credit](http://www.bcbsmt.com) to help you pay for a [plan](http://www.bcbsmt.com) through the [Marketplace](http://www.bcbsmt.com).

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](http://www.bcbsmt.com) 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>	\$500
■ <u>Specialist copayments</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,560

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>	\$500
■ <u>Specialist copayments</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,560

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayments</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$780

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

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>