**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsmt.com/Pages/policyforms.aspx or by calling 1-855-258-8471.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$6,250** person/**$12,500** family In-Network<br>**$12,500** person/**$25,000** family Out-of-Network<br>Doesn't apply to services from Native American providers, services that charge a copay, diabetic education, hospice, mammograms, prescription drugs, preventive health, and well-child. Copays and per occurrence deductibles don't count toward the overall deductible. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. ER **$500**; Inpatient **$250**/**$350**; and Outpatient **$200**/**$300**. There are no other specific **deductibles**. | You must pay all the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. **$6,250** person/**$12,500** family In-Network<br>**$12,500** person/**$25,000** family Out-of-Network | The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **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**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 3 describes any limits on what the insurer will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.bcbsmt.com **or call 1-855-258-8471** for a list of participating providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or |



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| Important Questions | Answers | Why this Matters: |
|---|---|---|
| | | participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- The plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Native American Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No Charge | $40 copay/visit | No Charge after Deductible | ---none--- |
| | Specialist visit | No Charge | $70 copay/visit | No Charge after Deductible | |
| | Other practitioner office visit | No Charge | No Charge after Deductible | No Charge after Deductible | 10 visit maximum per benefit period for chiropractic treatments.<br>12 visit maximum per benefit period for acupuncture treatments. |
| | Preventive care/screening/immunization | No Charge | No Charge | No Charge | One breast pump per birth event. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | No Charge after Deductible | No Charge after Deductible | ---none--- |
| | Imaging (CT / PET scans, MRIs) | No Charge | No Charge after Deductible | No Charge after Deductible | |

| Common Medical Event | Services You May Need | Your Cost If You Use a Native American Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbsmt.com/Pages/Pharmacy.aspx | Preferred generic | No Charge | No Charge | 50% of the Average Wholesale Price (AWP) | Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription - in-network only). 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. |
| | Non-preferred generic | No Charge | Retail: $10 copay<br>Mail: $20 copay | $10 copay in addition to 50% of the AWP | |
| | Preferred brand-name (Formulary) | No Charge | Retail: $50 copay<br>Mail: $100 copay | $50 copay in addition to 50% of the AWP | |
| | Non-preferred brand-name (Non-Formulary) | No Charge | Retail: $100 copay<br>Mail: $200 copay | $100 copay in addition to 50% of the AWP | |
| | Specialty pharmaceuticals | No Charge | $150 copay | $150 copay in addition to 50% of the AWP | Covers up to a 30-day supply only. Preauthorization required out-of-network. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | No Charge after Deductible | No Charge after Deductible | Additional $200 in-network/ $300 out-of-network per occurrence deductible charged in addition to overall deductible and coinsurance. Elective abortion is not covered. |
| | Physician/surgeon fees | No Charge | No Charge after Deductible | No Charge after Deductible | |

| Common Medical Event | Services You May Need | Your Cost If You Use a Native American Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | No Charge | No Charge after Deductible | No Charge after Deductible | Additional $500 per occurrence deductible charged in addition to overall deductible and coinsurance; waived if admitted. |
| | Emergency medical transportation | No Charge | No Charge after Deductible | No Charge after Deductible | ---none--- |
| | Urgent care | No Charge | $75 copay/visit | $75 copay/visit | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | No Charge after Deductible | No Charge after Deductible | Additional $250 in-network/ $350 out-of-network per occurrence deductible charged in addition to overall deductible and coinsurance. Preauthorization required. |
| | Physician/surgeon fee | No Charge | No Charge after Deductible | No Charge after Deductible | ---none--- |

| Common Medical Event | Services You May Need | Your Cost If You Use a Native American Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No Charge | $40 copay/office visits or No Charge after Deductible for other outpatient services | No Charge after Deductible | Inpatient: $250 In-Network/ $350 Out-of-Network per occurrence deductible is in addition to deductible and coinsurance. Preauthorization required. Residential treatment facilities will be covered if medical necessity criteria is met. |
| | Mental/Behavioral health inpatient services | No Charge | No Charge after Deductible | No Charge after Deductible | |
| | Substance use disorder outpatient services | No Charge | $40 copay/office visits or No Charge after Deductible for other outpatient services | No Charge after Deductible | |
| | Substance use disorder inpatient services | No Charge | No Charge after Deductible | No Charge after Deductible | |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | $40 copay/visit | No Charge after Deductible | Copay charged for initial visit only. |
| | Delivery and all inpatient services | No Charge | No Charge after Deductible | No Charge after Deductible | Additional $250 in-network/ $350 out-of-network per occurrence deductible charged in addition to overall deductible and coinsurance. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Native American Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No Charge | No Charge after Deductible | No Charge after Deductible | 180 visit maximum per benefit period. Preauthorization required. |
| | Rehabilitation services | No Charge | No Charge after Deductible | No Charge after Deductible | ---none--- |
| | Habilitation services | No Charge | $70 copay/visit | No Charge after Deductible | No Applied Behavior Analysis (ABA) benefits for Autism Spectrum Disorder available for members 19 years of age or older. |
| | Skilled nursing care | No Charge | No Charge after Deductible | No Charge after Deductible | Additional $250 in-network/ $350 out-of-network per occurrence deductible charged in addition to overall deductible and coinsurance. 60 days maximum per benefit period. Preauthorization required. |
| | Durable medical equipment | No Charge | No Charge after Deductible | No Charge after Deductible | ---none--- |
| | Hospice service | No Charge | No Charge | No Charge | |
| **If your child needs dental or eye care** | Eye exam | No Charge | No Charge | No Charge | One exam per benefit period for children under age 19. |
| | Glasses | No Charge | No Charge after Deductible | No Charge after Deductible | One pair of glasses per benefit period for children under age 19. |
| | Dental check-up | Not Covered | Not Covered | Not Covered | ---none--- |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Dental Care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Termination of pregnancy (Except in limited circumstances)

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Chiropractic care
- Cosmetic surgery (Only for the correction of a condition resulting from an accident, a condition resulting from an injury or to treat a congenital anomaly)
- Infertility treatment (With the exception of in vitro fertilization and prescription medications)
- Routine foot care (Only for a person with co-morbidities, such as diabetes)
- Weight loss programs (Preventative services only)

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-8471. You may also contact your state insurance department at http://www.csi.mt.gov/industry/insurance.asp.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Blue Cross and Blue Shield of Montana at 1-800-447-7828, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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 http://www.csi.mt.gov.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-8471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-8471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-8471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-8471.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

### This is not a cost estimator.

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,140
- **Patient pays** $6,400

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $6,250 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$6,400** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $50
- **Patient pays** $5,350

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $5,270 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$5,350** |

# Questions and answers about Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.