



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/bb/ind/bb_bosa86blcimtp_mt_2025.pdf or by calling 1-855-258-8471. 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:
<u>What is the overall deductible?</u>	In-Network: \$7,500 Individual / \$15,000 Family Out-of-Network: \$30,000 Individual / \$60,000 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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. In-Network <u>Preventive Care</u> services, services with a <u>copayment</u> , some <u>prescription drugs</u> , and In-Network hospice are covered before you meet your deductible.	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 www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	Yes. Inpatient Out-of-Network Facility \$2,000; Outpatient Surgery Facility Out-of-Network \$2,000. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<u>What is the out-of-pocket limit for this plan?</u>	In-Network: \$9,200 Individual / \$18,400 Family Out-of-Network: \$36,800 Individual / \$73,600 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.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.bcbsmt.com/bluefocuspos or call 1-855-258-8471 for a list of In-Network <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.
<u>Do you need a referral to see a specialist?</u>	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 (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	\$50/visit; deductible does not apply	50% coinsurance	Virtual Visits: \$50/visit. See your contract* for details.
	Specialist visit	\$100/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	50% 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)	50% coinsurance	50% coinsurance	Preauthorization may be required; see your contract* for details.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	Preauthorization may be required; see your contract* for details.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsmt.com/rx25/4T	Generic drugs	Retail: Value - \$25/prescription Participating - \$25/prescription Mail: \$75/prescription; deductible does not apply	Retail: \$25/prescription; 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 mail order. Specialty drugs are limited to a 30-day supply except for certain FDA-designated dosing regimens.
	Brand drugs (Preferred)	Retail: Value - \$50/prescription Participating - \$50/prescription Mail: \$150/prescription	Retail: \$50/prescription	Payment of the difference between the cost of a brand name drug and a generic drug equivalent may also be required if a generic drug equivalent is available.
	Brand drugs (Non-Preferred)	Retail: Value - \$100/prescription Participating - \$100/prescription Mail: \$300/prescription	Retail: \$100/prescription	All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copay/coinsurance . Additional charge will not apply to any deductible or out-of-pocket amounts.
	Specialty drugs	\$500/prescription	\$500/prescription	A covered insulin drug will not exceed \$25 copayment for a 30-day supply.

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)	50% <u>coinsurance</u>	\$2,000/visit plus 50% <u>coinsurance</u>	Preauthorization may be required. For Outpatient Infusion Therapy, see your contract* for details.
	Physician/surgeon fees	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your contract* for details.
	<u>Urgent care</u>	\$75/visit; <u>deductible</u> does not apply	\$75/visit; <u>deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	\$2,000/visit plus 50% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Physician/surgeon fees	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50/office visit; <u>deductible</u> does not apply 50% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your contract* for details.
	Inpatient services	50% <u>coinsurance</u>	\$2,000/visit plus 50% <u>coinsurance</u>	<u>Preauthorization</u> required. Residential treatment facilities will be covered if medical necessity criteria are met.
If you are pregnant	Office visits	Primary Care: \$50/initial visit <u>Specialist</u> : \$100/initial visit; <u>deductible</u> does not apply	50% <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).
	Childbirth/delivery professional services	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	50% <u>coinsurance</u>	\$2,000/visit plus 50% <u>coinsurance</u>	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/bb/ind/bb_bosa86blcimtp_mt_2025.pdf

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>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required. 180-visit maximum per benefit period.
	<u>Rehabilitation services</u>	\$50/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Preauthorization may be required. Includes physical, occupational and speech therapy.
	<u>Habilitation services</u>	\$50/visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required. 60-day maximum per benefit period.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	Inpatient: \$2,000/visit plus 50% <u>coinsurance</u> Outpatient: 50% <u>coinsurance</u>	Preauthorization may be 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	One exam per benefit period for children under age 19.
	Children's glasses	50% <u>coinsurance</u>	50% <u>coinsurance</u>	One pair of glasses or one pair of contact lenses per benefit period for children under age 19.
	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.)

- Abortion (except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
 - Long-term care
 - Non-emergency care when traveling outside the U.S.
 - Private-duty nursing
 - Routine eye care (Adult)
 - Weight loss programs (with the exception of preventive services)
- Bariatric surgery
 - Dental care (Adult)

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 (10-visit maximum per benefit period)
- Cosmetic surgery (when medically necessary)
- Hearing aids (for a covered child 18 years of age or younger, limited to 1 item per ear every 3 years or as required by a licensed audiologist)
- Infertility treatment (with the exception of in vitro fertilization and prescription medications)
- Routine foot care (when medically necessary)

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 1-855-258-8471, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact your state insurance department at www.csi.mt.gov/industry/insurance.asp. 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 1-855-258-8471, 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 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.

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? Not Applicable

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 1-855-258-8471.

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 a'ohwol ninisingo, kwijjigo holne' 1-855-258-8471.

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)

■ <u>The plan's overall deductible</u>	\$7,500
■ <u>Specialist copayment</u>	\$100
■ <u>Hospital (facility) coinsurance</u>	50%
■ <u>Other coinsurance</u>	50%

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*)

Managing Joe's Type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$7,500
■ <u>Specialist copayment</u>	\$100
■ <u>Hospital (facility) coinsurance</u>	50%
■ <u>Other coinsurance</u>	50%

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*)

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$7,500
■ <u>Specialist copayment</u>	\$100
■ <u>Hospital (facility) coinsurance</u>	50%
■ <u>Other coinsurance</u>	50%

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	\$12,700
In this example, Peg would pay:	

Total Example Cost	\$5,600
In this example, Joe would pay:	

Total Example Cost	\$2,800
In this example, Mia would pay:	

Cost Sharing	
<u>Deductibles</u>	\$7,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,700

Cost Sharing	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0

Cost Sharing	
<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0

What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$9,260

What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,600

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

**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	للتلقى 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.
हिन्दी	नि:शुल्क 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'sá'góó, shá ata' hodooni nínízingo, t'áajíík'eh bee náhaz'á. 1-866-560-4042 ji' 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 لئے، براہ کرم بیمیں 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.