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 costs, visit *Choices* or call the Plan Administrator at 1-877-501-1722. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, visit Glossary of Health Coverage and Medical Terms or call the Plan Administrator at 1-877-501-1722 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,250/Individual or $2,500/Family In-Network	You must pay all of the costs from providers up to the deductible amount before the Plan begins to pay. Deductible applies to all services, unless otherwise indicated, or a copayment applies.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care and specialist provider office visits are covered before you meet your deductible.	The Plan covers some services even if you haven't met the deductible amount, but 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 Preventive Health Services.
Are there other deductibles for specific services?	Yes. $2,500/Individual or $5,000/Family Out-of-Network	You must pay all of the costs from out-of-network providers up to the deductible amount before the Plan begins to pay.
What is the out-of-pocket limit for this Plan?	$4,350/Individual or $8,700/Family In-Network $6,000/Individual or $12,000/Family Out-of-Network	The out-of-pocket limit is the most you could pay in a Plan 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 In-Network provider?	Yes. Visit BlueCross BlueShield of Montana or call 1-800-820-1674 for a list of In-Network participating providers.	You will pay less if you use an In-Network provider. You will pay the most if you use an Out-of-Network provider, and you may receive a bill from a provider for the difference between the provider's charge and what your Plan pays (balance billing). Be aware, your In-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 a specialist without a referral or permission from the Plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary Care Provider (PCP) office visit to treat an injury or illness, includes Naturopathic and Telemedicine visits.	$30 copay/office visit; 30% coinsurance for other outpatient services; deductible applies	40% coinsurance; deductible applies	Office visit limited to evaluation and management charges. All other charges are subject to deductible and coinsurance. Naturopathic services- You may be responsible for balance billing.
	Specialist Provider office visit	$50 copay/office visit; 30% coinsurance for other outpatient services; deductible applies	40% coinsurance; deductible applies	Office visit limited to evaluation and management charges. All other charges are subject to deductible and coinsurance.
	Preventive care/screening/ Immunization	0%	40% coinsurance; deductible applies	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your Plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance; deductible applies	40% coinsurance; deductible applies	
	Imaging (CT/PET scans, MRIs)	30% coinsurance; deductible applies	40% coinsurance; deductible applies	May require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Navitus Health Solutions.		**Retail (34-day supply)**	**Retail or Mail Order (90-day supply)**	
	Certain Preventive Drugs- (Tier $0)	$0 copay	$0 copay	Covers up to a 34-day supply (retail prescription); 90-day supply (retail or mail order prescription).
	Preferred brand drugs- (Tier 1) (Tier 2)	$15 copay $50 copay	$30 copay $100 copay	
	Non-preferred brand drugs-			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider	Out of Network Provider	
	(Tier 3)	50% coinsurance	50% coinsurance	50% coinsurance does not apply to annual prescription out-of-pocket limit.
	Specialty drugs (Tier 4) Out-of-Pocket Limit- $2,150/Individual or $4,300/Family	$200 copay (preferred specialty pharmacy) 50% coinsurance (retail or out-of-network pharmacy)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance; deductible applies	40% coinsurance; deductible applies	None.
	Physician/surgeon fees	30% coinsurance; deductible applies	40% coinsurance; deductible applies	None.
If you need immediate medical attention	Emergency Room care	$250 copay/visit; 30% coinsurance for other outpatient services; deductible applies	$250 copay/visit; 25% coinsurance for other outpatient services; deductible applies	None. Medical emergency only or from one facility to another for a higher level of care. Office visit limited to evaluation and management charges. All other charges are subject to deductible and coinsurance.
	Emergency medical transportation	$200 copay/transport	$200 copay/transport	
	Urgent Care	$75 copay/visit; 30% coinsurance for other outpatient services; deductible applies	$75 copay/visit; 25% coinsurance for other outpatient services; deductible applies	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance; deductible applies	40% coinsurance; deductible applies	Pre-certification recommended for all inpatient admissions.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider	Out of Network Provider	
	Physician/surgeon fees	30% coinsurance; deductible applies	40% coinsurance; deductible applies	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	1st 4 visits at $0, then $30 copay/visit Psychiatrist- $50 copay/visit	40% coinsurance; deductible applies	1st 4 visits at $0 copay/visit- mental health, behavioral health, and substance abuse combined visits (excludes psychiatrist).
	Inpatient services	30% coinsurance; deductible applies	40% coinsurance; deductible applies	
If you are pregnant	Office visits	$30 copay/visit	40% coinsurance; deductible applies	None.
	Childbirth/delivery professional services	30% coinsurance; deductible applies	40% coinsurance; deductible applies	
	Childbirth/delivery facility services	30% coinsurance; deductible applies	40% coinsurance; deductible applies	
If you need help recovering or have other special health needs	Home Health Care	$30 copay/visit	40% coinsurance; deductible applies	Prior authorization is recommended/max 30 visits/year.
	Outpatient Rehabilitative services visit- physical, speech, occupational, pulmonary, cardiac, respiratory, and medical massage therapies; chiropractic; acupuncture	$30 copay/visit	40% coinsurance; deductible applies	Outpatient maximum 60 visits/year- all outpatient rehabilitative services combined. Massage therapy and Acupuncture services- You may be responsible for balance billing.
	Inpatient Rehabilitative services	30% coinsurance; deductible applies	40% coinsurance; deductible applies	Inpatient maximum 30 days/year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider	Out of Network Provider	
	Skilled Nursing Facility	30% coinsurance; deductible applies	40% coinsurance; deductible applies	Prior authorization is recommended/max 30 days/year.
	Durable Medical Equipment	30% coinsurance; deductible applies	40% coinsurance; deductible applies	
	Hospice services	30% coinsurance; deductible applies	40% coinsurance; deductible applies	Maximum is 6 months.
If you need dental or eye care	Eye exam ***covered by medical plan	0%	40% coinsurance; deductible applies	Limited to one exam per year (routine or medical).
	Optional Vision Hardware *** BlueCross BlueShield of Montana			Up to $300- 1 pair of eyeglass frames and lenses, in lieu of contact lenses/year. Up to $200- 1 purchase of contact lenses, in lieu of eyeglass frames and lenses/year.
	Dental *** Delta Dental	Fee schedule payment.	Fee schedule payment.	Select Plan covers up to $1,500/individual

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your Plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Infertility Treatment
- Homeopathic services
- Non-surgical treatment of TMJ
- Work related accident/illness
- Routine Foot Care

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

- Hearing Aids
- Organ transplant
- Private Duty Nursing
- Emergency Care when traveling outside of the U.S.
- Medically necessary travel with prior authorization
- Bariatric Surgery

Your Rights to Continue Coverage: If you lose coverage under the Plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the Plan. Other limitations on your rights to continue coverage may also apply.

You can keep this coverage as long as your premiums are paid, unless your employment terminates, or hours worked drop below 20. If you have no other coverage, you can choose to keep this coverage by electing COBRA (Consolidated Omnibus Budget Reconciliation Act). See your campus Human

Resources/Benefits office for rules regarding election of COBRA benefits and making premium payments.

For more information on your rights to continue coverage, visit *Choices* or call the Plan at 1-877-501-1722.

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 HealthCare.gov or call 1-800-318-2596.

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 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, call BlueCross BlueShield of Montana at 1-800-820-1674, visit *Choices*, or call the Plan at 1-877-501-1722.

Does this Plan provide Minimum Essential Coverage? Yes.
The Affordable Care Act requires people to have health care coverage that qualifies as "minimum essential coverage." **This Plan does provide** Minimum Essential Coverage.

If you don't have Minimum Essential Coverage 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 Minimum Value Standards? Yes.
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. **This health coverage does meet the** Minimum Value Standards **for the benefits it provides.**

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.

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. Pease note these coverage examples are based on self-only coverage.

Having a Baby
(9 months of In Network pre natal care and a hospital delivery)

The Plan's overall deductible	$120
Primary Care office visit copayment	$30
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary Care office visit (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Other services *(anesthesia)*

Total Example Cost	**$12,800**

In this example, patient would pay:

Cost Sharing	
Deductible	$1,250
Primary Care Office Visit Copayment	$30
Coinsurance	$3,070.00
What isn't covered	
Limits or exclusions	$0
The total patient would pay is	**$4,350.00**

Managing Type 2 Diabetes
(a year of routine In Network care of a well controlled condition)

The Plan's overall deductible	$1250
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visit (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs

Total Example Cost	**$7,400**

In this example, patient would pay:

Cost Sharing	
Deductible	$1,250
Specialist Office Visit Copayment	$50
Prescription Copayment	$50
Coinsurance	$1,845.00
What isn't covered	
Limits or exclusions	$0
The total patient would pay is	**$3,195.00**

Simple Fracture
(In Network emergency room visit and follow up care)

The Plan's overall deductible	$1250
Emergency Room copayment	$250
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency Room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Outpatient Rehabilitative services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, patient would pay:

Cost Sharing	
Deductible	$1,250
Emergency Room Copayment	$250
Physical Therapy Visit Copayment	$30
Coinsurance	$195.00
What isn't covered	
Limits or exclusions	$0
The total patient would pay is	**$1,725.00**