The Summary of Benefits and Coverage (SBC) document indicates how you and the Plan would share the cost for covered health care services per Plan Year. 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 contact the MUS 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 contact the MUS 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 $3,125/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 covered 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 pays for some covered 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 $6,250/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?	$4,500/Individual or $11,250/Family In-Network $6,750/Individual or $16,875/Family Out-of-Network	The out-of-pocket limit is the most you will pay in a Plan Year for covered services. If you have other family members in this Plan, they must 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 may use an Out-of-Network provider for some covered 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 covered specialist without a referral or permission from the Plan.

All **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	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 visits are limited to evaluation and management charges. All other charges are subject to deductible and coinsurance. Naturopathic services- You may be responsible for balance billing.
	Federally Qualified Health Center (FQHC) visit	$10 copay/office visit	N/A	Office visit includes all covered services rendered by the FQHC during the visit. No deductible or coinsurance applies.
	MD LIVE virtual visit (telemedicine)	$10 copay/virtual visit	N/A	No deductible or coinsurance applies.
	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	May require prior authorization.
	Imaging (CT/PET scans, MRIs)	30% coinsurance; deductible applies	40% coinsurance; deductible applies	

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Navitus Health Solutions.	Certain preventive drugs- (Tier $0)	**Retail (34-day supply)** $0 copay	**Retail or Mail Order (90-day supply)** $0 copay	Covers up to a 34-day supply (retail prescription); 90-day supply (retail or mail order prescription). 50% coinsurance does not apply to annual prescription out-of-pocket limit.
	Preferred brand drugs- (Tier 1) (Tier 2)	$15 copay $50 copay	$30 copay $100 copay	
	Non-preferred brand drugs- (Tier 3)	50% coinsurance	50% coinsurance	
	Specialty drugs (Tier 4) Out-of-Pocket Limit- $2,150/Individual or $4,300/Family (Commercial Plan) $2,000/Individual (MedicareRx Plan)	$200 copay (preferred specialty pharmacy) 50% coinsurance (retail or out-of-network pharmacy)		

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 have outpatient surgery	Facility fee (e.g., outpatient hospital or 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.
	Emergency medical transportation	$200 copay/transport	$200 copay/transport	Medical emergency only or from one facility to another for a higher level of care.
	Urgent Care	$75 copay/visit; 30% coinsurance for other outpatient services; deductible applies	$75 copay/visit; 25% coinsurance for other outpatient services; deductible applies	Office visit limited to evaluation and management charges. All other charges are subject to deductible and coinsurance.

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 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.
	Physician/surgeon fees	30% coinsurance; deductible applies	40% coinsurance; deductible applies	None.
If you need mental health or substance use disorder services	Outpatient services	1st 4 visits at $0, then $30 copay/visit	40% coinsurance; deductible applies	Combined maximum of 4 visits at $0 copay for mental health and substance use disorder services.
	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/maximum of 30 visits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
	Outpatient Rehabilitative services visit- physical, speech, occupational, pulmonary, cardiac, respiratory, and medical massage therapies, acupuncture, and chiropractic	$30 copay/visit	40% coinsurance; deductible applies	Combined outpatient maximum of 60 visits for all covered outpatient rehabilitative services. 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 of 30 days.
	Skilled Nursing Facility	30% coinsurance; deductible applies	40% coinsurance; deductible applies	Prior authorization is recommended/maximum of 30 days.
	Durable Medical Equipment	30% coinsurance; deductible applies	40% coinsurance; deductible applies	
	Hospice services	30% coinsurance; deductible applies	40% coinsurance; deductible applies	Maximum of 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 Plan Year (routine or medical).
	Optional Vision Hardware			Up to $300 allowance- 1 pair of eyeglass frames and lenses, in lieu of contact lenses per

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
	*** BlueCross BlueShield of Montana			Plan Year. Up to $200 allowance- 1 pair or one single purchase of contact lenses, in lieu of eyeglass frames and lenses per Plan Year.
	Dental *** Delta Dental	Fee schedule payment.	Fee schedule payment.	Select Plan covers up to $2,000/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. Check your Plan document for more information on covered services.)

- Hearing Aids
- Hearing Exams
- 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 may keep this coverage as long as your premiums are paid. See your campus Human Resources/Benefits office regarding benefits and making premium payments.

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

Other coverage options may be available to you, 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 need assistance, contact BlueCross BlueShield of Montana at 1-800-820-1674, visit *Choices*, or contact the MUS Plan Administrator 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.**

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 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
(In-Network pre-natal care and hospital delivery)

The Plan's overall deductible	$1250
Primary Care office visit copayment	$30
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services:
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**

Managing Type 2 Diabetes
(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:
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**

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:
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**