



**BlueCross BlueShield
of Montana**

Blue Cross and Blue Shield of Montana (BCBSMT) monitors employers' distribution of the Summary of Benefits and Coverage (SBC) to its employees. The employer, or its group health plan, has contractually agreed (through the Benefit Program Application) to distribute the SBC to participants and beneficiaries.

Earlier this year, you attested to providing the SBC to your employees. We are now performing a random SBC performance audit. **Please submit certification of distribution within 30 days by signing and submitting this document electronically and include evidence, if applicable.** You may also submit the form via mail or fax to:

Blue Cross Blue Shield of Montana
Attn: Melonie Dulaney – 22.121A
300 East Randolph
Chicago, IL 60601

Email: StandardSBCRequests@bcbsil.com
Fax: 312-653-0807

Indicate the method in which you distributed SBCs to your employees and include an example with this form:

- Mail** – A cover letter that was attached to the SBC
- Email** – A copy of the email sent or cover letter sent in the email
- Website URL** – A link where the SBC is provided and/or copy of the notification
- Hand delivered**

Date of delivery: _____

TO BE SIGNED BY THE GROUP REPRESENTATIVE:

I, the undersigned, a duly authorized representative of the policyholder named above (Policyholder), hereby represent: (i) the Policyholder is knowledgeable as to standards associated with the distribution of the SBC as set forth in the Affordable Care Act, applicable regulations, and sub-regulatory guidance, and (ii) the information contained in this form is true, complete, and accurate.

I provided the SBC to all plan participants and beneficiaries as required by the SBC regulations (at 45 CFR 147.200) and sub-regulatory guidance.

Signature

Title

Print Name

Date

Group/Account Number