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 https://www.bcbsmt.com/policy-forms/2019/GPSH30PPOIMTP.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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$450 person/$900 family In-Network $1,800 person/$3,600 family Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health, services with a copay, prescription drugs, and In-Network hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. ER $1,000; Inpatient $850/$1,500; Outpatient Surgery Facility Out-of-Network $1,500. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$7,900 person/$15,800 family In-Network $31,600 person/$63,200 family Out-of-Network	The out-of-pocket limit is the most you could pay in a 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-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.
Will you pay less if you use a network provider?	Yes. See www.bcbsmt.com or call 1-855-258-8471 for a list of In-Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your 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 the specialist you choose without a referral.

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 In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First 2 visits $10 each, then 30% coinsurance for subsequent visits	50% coinsurance	First 2 office visits, you pay $10 each; you pay deductible and coinsurance for subsequent visits. Virtual Visits: $10/visit. See your contract* for details.
	Specialist visit	30% coinsurance	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)	30% coinsurance	50% coinsurance	Preauthorization may be required; see your contract* for details.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at https://www.bcbsmt.com/policy-forms/2019/GPSH30PPOIMTP.pdf.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/HIM/2019/2019_MT_6T_HIM.pdf	Preferred generic drugs	Retail - Preferred - $5/prescription Non-Preferred - $10/prescription Mail - $15/prescription; deductible does not apply	Retail - $10/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 limited to a 30-day supply. 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. 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.
	Non-preferred generic drugs	Retail - Preferred - $10/prescription Non-Preferred - $20/prescription Mail - $30/prescription; deductible does not apply	Retail - $20/prescription; deductible does not apply	
	Preferred brand drugs	Retail - Preferred - $50/prescription Non-Preferred - $70/prescription Mail - $150/prescription; deductible does not apply	Retail - $70/prescription; deductible does not apply	
	Non-preferred brand drugs	Retail - Preferred - $100/prescription Non-Preferred - $120/prescription Mail - $300/prescription; deductible does not apply	Retail - $120/prescription; deductible does not apply	
	Preferred specialty drugs	$250/prescription; deductible does not apply	$250/prescription; deductible does not apply	
	Non-Preferred specialty drugs	$350/prescription; deductible does not apply	$350/prescription; deductible does not apply	

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)	30% coinsurance	$1,500/visit plus 50% coinsurance	Preauthorization may be required. Abortion is not covered except in limited circumstances. For Outpatient Infusion Therapy, see your contract* for details.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$1,000/visit plus 30% coinsurance	$1,000/visit plus 30% coinsurance	Per occurrence deductible waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Preauthorization may be required for non-emergency transportation; see your contract* for details.
	Urgent care	$15/visit; deductible does not apply	$15/visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$850/visit plus 30% coinsurance	$1,500/visit plus 50% coinsurance	Preauthorization required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Outpatient: Preauthorization may be required; see your contract* for details. Inpatient: Preauthorization required. Residential treatment facilities will be covered if medical necessity criteria are met.
	Inpatient services	$850/visit plus 30% coinsurance	$1,500/visit plus 50% coinsurance	
If you are pregnant	Office visits	$10 or 30% coinsurance for initial visit, then No Charge for subsequent visits	50% coinsurance	$10 for initial visit, or 30% coinsurance for initial visit if 2 office visits at $10 per visit have previously been incurred. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$850/visit plus 30% coinsurance	$1,500/visit plus 50% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at https://www.bcbsmt.com/policy-forms/2019/GPSH30PPOIMTP.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	Home health care	30% coinsurance	50% coinsurance	Preauthorization may be required. 180 visit maximum per benefit period.
	Rehabilitation services	30% coinsurance	50% coinsurance	Preauthorization may be required. Includes physical, occupational and speech therapy.
	Habilitation services	30% coinsurance	50% coinsurance	Preauthorization may be required. No Applied Behavior Analysis (ABA) benefits for Autism Spectrum Disorder available for members 19 years of age or older.
	Skilled nursing care	30% coinsurance	50% coinsurance	Preauthorization may be required. 60 days maximum per benefit period.
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Hospice services	No Charge; deductible does not apply	50% coinsurance	
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	No Charge; deductible does not apply	One exam per benefit period for children under age 19.
	Children's glasses	30% coinsurance	50% coinsurance	One pair of glasses 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)
- Bariatric surgery
- Dental Care (Adult)
- Hearing aids (With the exception of medically necessary cochlear implants, per medical policy)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (With the exception of person with co-morbidities, such as diabetes)
- Weight loss programs (With the exception of preventive services)

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 (Only for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)	• Infertility treatment (With the exception of in vitro fertilization and prescription medications)

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. You may also contact your state insurance department at http://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 (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 http://www.csi.mt.gov.

Does this plan provide Minimum Essential Coverage? Yes

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 the Minimum Value Standards? Yes

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 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 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)

- **The plan's overall deductible** $450
- **Specialist coinsurance** 30%
- **Hospital (facility) copay/coins.** $850 + 30%
- **Other coinsurance** 30%

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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$450
Copayments	$900
Coinsurance	$3,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,810**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $450
- **Specialist coinsurance** 30%
- **Hospital (facility) copay/coins.** $850 + 30%
- **Other coinsurance** 30%

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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$450
Copayments	$900
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,910**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $450
- **Specialist coinsurance** 30%
- **Hospital (facility) copay/coins.** $850 + 30%
- **Other coinsurance** 30%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

BlueCross BlueShield of Montana

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 speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don’t have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d’aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n’êtes pas membre ou si vous n’avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855–710–6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
Diné Navajo	T’áá ni, éí doodago ła’da bíká anánílwo’ígíí, na’ídíłkidgo, ts’ídá bee ná ahóóti’i’ t’áá níík’e níká a’doolwoł. Ata’ halne’í bich’į’ hadeesdzih nínízingo éí kwe’é da’íníishgi áká anídaalwo’ígíí bich’į’ hodíílnih, bee nééhózinii bine’dę́ę́’ bikáá’. Kojí atah naaltsoos ná hadít’éégóó éí doodago bee nééhózinígíí ádingo kojį’ hodíílnih 855-710-6984**.**
Norsk Norwegian	Hvis du, eller noen du hjelper, har spørsmål, har du rett til å få hjelp og informasjon på ditt språk uten kostnad. For å snakke med en tolk, ring kundeservicenummeret bakpå medlemskortet ditt. Hvis du ikke er medlem, eller ikke har kort, ring 855-710-6984.
Pennsilfaanisch Deitsch Pennsylvanian-Dutch	Wann du, odder ebber as du an helfe bischt, Questions hoscht, hoscht du’s Recht fer Hilf un Information griege in dei eegni Schprooch as nix koschte zellt. Wann du en Dolmetscher mitschwetze wettscht, kannscht du die Customer Service Nummer an deinre Glied-Kard dahinner uffrufe. Wann du net en Glied bischt, odder kee Kard hoscht, kannscht du 855-710-6984 uffrufe.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
Українська Ukrainian	Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання, у Вас є право отримати безкоштовну допомогу та інформацію Вашою рідною мовою. Щоб зв’язатися з перекладачем, телефонуйте за номером обслуговування клієнтів , який зазначено на звороті вашої картки учасника. Якщо ви не учасник програми, або у вас немає картки, телефонуйте за номером 855-710-6984.
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

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 or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

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	Phone: 855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD: 855-661-6965
35th Floor	Fax: 855-661-6960
Chicago, Illinois 60601	Email: CivilRightsCoordinator@hcsc.net

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	Phone: 800-368-1019
200 Independence Avenue SW	TTY/TDD: 800-537-7697
Room 509F, HHH Building 1019	Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html