**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-sosh31blcimtp-mt-2020.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?** | $4,000 person/ $8,000 family In-Network<br>$16,000 person/ $32,000 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, 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 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?** | $8,150 person/ $16,300 family In-Network<br>$32,600 person/ $65,200 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 | | 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 | First 2 visits $25 each, then 50% coinsurance for subsequent visits | 50% coinsurance | None |
| | Specialist visit | 50% coinsurance | 50% coinsurance | |
| | 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 | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/bb/ind/bb-sosh31blcimtp-mt-2020.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 drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbsmt.com/rx1 | Preferred generic drugs | Retail - Preferred - $5/prescription<br>Non-Preferred - $10/prescription<br>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 - $15/prescription<br>Non-Preferred - $25/prescription<br>Mail - $45/prescription; deductible does not apply | Retail - $25/prescription, deductible does not apply | |
| | Preferred brand drugs | Retail - Preferred - $50/prescription<br>Non-Preferred - $70/prescription<br>Mail - $150/prescription; deductible does not apply | Retail - $70/prescription, deductible does not apply | |
| | Non-preferred brand drugs | Retail - Preferred - $100/prescription<br>Non-Preferred - $120/prescription<br>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 | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance | $1,500/visit plus 50% coinsurance | Preauthorization may be required. Abortion is not covered except in limited circumstances.<br>For Outpatient Infusion Therapy, see your contract* for details. |
| | Physician/surgeon fees | 50% coinsurance | 50% coinsurance | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/bb/ind/bb-sosh31blcimtp-mt-2020.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 immediate medical attention** | Emergency room care | $1,000/visit plus 50% coinsurance | $1,000/visit plus 50% coinsurance | Per occurrence deductible waived if admitted. |
| | Emergency medical transportation | 50% coinsurance | 50% coinsurance | Preauthorization may be required for non-emergency transportation; see your contract* for details. |
| | Urgent care | $40/visit; deductible does not apply | $40/visit; deductible does not apply | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $850/visit plus 50% coinsurance | $1,500/visit plus 50% coinsurance | Preauthorization required. |
| | Physician/surgeon fees | 50% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 50% 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 50% coinsurance | $1,500/visit plus 50% coinsurance | |
| **If you are pregnant** | Office visits | $25 or 50% coinsurance for initial visit, then No Charge for subsequent visits | 50% coinsurance | $25 for initial visit, or 50% coinsurance for initial visit if 2 office visits at $25 per visit have previously been incurred. Cost sharing does not apply for 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 | 50% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | $850/visit plus 50% coinsurance | $1,500/visit plus 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 50% coinsurance | 50% coinsurance | Preauthorization may be required. 180 visit maximum per benefit period. |
| | Rehabilitation services | 50% coinsurance | 50% coinsurance | Preauthorization may be required. Includes physical, occupational and speech therapy. |
| | Habilitation services | 50% 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 | 50% coinsurance | 50% coinsurance | Preauthorization may be required. 60 days maximum per benefit period. |
| | Durable medical equipment | 50% coinsurance | 50% coinsurance | Preauthorization may be required. |
| | Hospice services | No Charge; deductible does not apply | 50% coinsurance | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/bb/ind/bb-sosh31blcimtp-mt-2020.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 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 | 50% 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 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** | $4,000 |
| **Specialist coinsurance** | 50% |
| **Hospital (facility) copay/coins.** | $850 + 50% |
| **Other coinsurance** | 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*)

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $4,000 |
| Copayments | $900 |
| Coinsurance | $3,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$8,260**** |

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

| | |
|---|---|
| **The plan's overall deductible** | $4,000 |
| **Specialist coinsurance** | 50% |
| **Hospital (facility) copay/coins.** | $850 + 50% |
| **Other coinsurance** | 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*)

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,100 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$3,160** |

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

| | |
|---|---|
| **The plan's overall deductible** | $4,000 |
| **Specialist coinsurance** | 50% |
| **Hospital (facility) copay/coins.** | $850 + 50% |
| **Other coinsurance** | 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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,900 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

**The figure provided here does not take into consideration the out-of-pocket limitation.

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 talk to an interpreter, call 855-710-6984.

| | |
|---|---|
| Español<br>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, llame al 855-710-6984. |
| العربية<br>Arabic | إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984. |
| 繁體中文<br>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，請撥電話 號碼 855-710-6984。 |
| Français<br>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, appelez 855-710-6984. |
| Deutsch<br>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 Nummer 855-710-6984 an. |
| ગુજરાતી<br>Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો. |
| हिंदी<br>Hindi | यिद आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा म निःशुल्क सहायता और जानकारी प्राप्त करन का अधिकार है। किसी अनवादक स बात करन क लिए 855-710-6984 पर कॉल करें। |
| Italiano<br>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 numero 855-710-6984. |
| 한국어<br>Korean | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오. |
| Diné<br>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 dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984. |
| فارسی<br>Persian | اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید. |
| Polski<br>Polish | Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984. |
| Русский<br>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 связаться с переводчиком, позвоните по телефону 855-710-6984. |
| Tagalog<br>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 855-710-6984. |
| اردو<br>Urdu | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔ |
| Tiếng Việt<br>Vietnamese | Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984. |

BlueCross BlueShield of Montana

**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, sexual orientation, health status 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
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
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
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/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html