The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 by calling 1-855-258-3489 or at www.bcbsmt.com. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,500 individual / \$3,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , virtual visits, and generic <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	\$3,000 individual / \$6,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums, balance-billing</u> charges, and health care this <u>plan</u> 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 <u>network provider</u> ?	Yes. See <u>www.bcbsmt.com</u> or call 1-855-258-3489 for a list of participating <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. You don't need a <u>referral</u> to see a <u>specialist</u> .	You can see the specialist you choose without a referral.

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common	Services You May Need	What Yoเ	ı Will Pay	Limitations, Exceptions, & Other	
Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% coinsurance	Virtual visits available through MDLive; \$40 <u>copay</u> until <u>deductible</u> is met, then 20% <u>coinsurance</u> .	
lf you visit a health	<u>Specialist</u> visit	20% coinsurance	20% coinsurance	None	
care <u>provider's</u> office or clinic	Preventive care/screening/immunization	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Maximum of one electric breast pump per year. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.	
IF 1 1 1 1	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your member guide* for details.	
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance		
If you need drugs to treat your illness or condition	Generic drugs	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply		
More information about prescription drug <u>coverage</u> is available at	Brand name drugs - <u>Formulary</u>	20% <u>coinsurance</u>	20% coinsurance	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription).	
www.bcbsmt.com/mem ber/prescription-drug- plan-information/drug- lists.	Brand name drugs - Non- <u>Formulary</u>	20% <u>coinsurance</u>	20% coinsurance		

		What You			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	<u>Out-of-Network</u> <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Preauthorization may be required; see you	
outpatient surgery	Physician/surgeon fees	20% coinsurance	20% coinsurance	member guide* for details.	
	Emergency room care	20% <u>coinsurance</u>	20% coinsurance	None	
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your member guide* for details.	
	<u>Urgent care</u>	20% coinsurance	20% coinsurance	None	
If you have a	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% coinsurance	Preauthorization is required.	
hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	20% coinsurance		
If you need mental	Outpatient services	20% coinsurance	20% coinsurance	Outpatient: <u>Preauthorization</u> may be required; see your member guide* for details. Inpatient: <u>Preauthorization</u> required. Residential treatment facilities will be covered if medical necessity criteria are met.	
health, behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>		
lf you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery professional services	20% coinsurance	20% <u>coinsurance</u>		
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% coinsurance		

		What You	Will Pay	
Common Medical Event	Services You May Need	<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network</u> <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	20% coinsurance	20% coinsurance	<u>Preauthorization</u> may be required. 100-visit maximum per benefit period.
	Rehabilitation services	20% coinsurance	20% <u>coinsurance</u>	Dreautharization may be required
lf you need help	Habilitation services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization may be required.
recovering or have other special health needs	Skilled nursing care	20% coinsurance	20% coinsurance	<u>Preauthorization</u> may be required. 90 days maximum per benefit period.
	Durable medical equipment	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required. 20% <u>coinsurance</u> for repair and replacement.
	Hospice services	20% coinsurance	20% coinsurance	Preauthorization may be required.
	Children's eye exam	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded services & Other Covered Services:

Chiropractic care

Cosmetic surgery

Dental care (Adult)

•

•

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

 • Acupuncture
 • Hearing aids
 • Non-emergency care when traveling outside the U.S.

 • Bariatric surgery
 • Infertility treatment
 • Routine eye care (Adult)

- Long-term care
- Private-duty nursing

- Routine foot care
- Weight loss programs

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

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 <u>plan</u> at 1-855-258-3489 U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance</u> <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your <u>Grievance</u> and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Montana at 1-855-258-3489 the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit <u>www.dol.gov/ebsa/healthreform</u>, or the Montana Commissioner of Securities and Insurance at 1-406-444-2040 or 1-800-332-6148 Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or visit <u>www.csi.mt.gov</u>.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-855-258-3489. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-3489. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-258-3489. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-3489.

-To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of <u>in-network</u> pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine <u>in-network</u> care of a well- controlled condition)		Mia's Simple Fracture (<u>in-network</u> emergency room visit and follow up care)	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,500 20% 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,500 20% 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,500 20% 20% 20%
This EXAMPLE event includes services <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood w</i> <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes servicePrimary care physicianoffice visits (includisease education)Diagnostic tests(blood work)Prescription drugsDurable medical equipment (glucose medical)	ding	This EXAMPLE event includes serv Emergency room care (including med supplies) Diagnostic test (x-ray) Durable medical equipment (crutches Rehabilitation services (physical thera)
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		Cost Sharing		<u>Cost Sharing</u>	
Deductibles	\$1,500	Deductibles	\$1,500	Deductibles	\$1,500
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
Coinsurance	\$1,500	Coinsurance	\$700	Coinsurance	\$300
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$3,060	The total Joe would pay is	\$2,220	The total Mia would pay is	\$1,800



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.

الحربية	إن كان لديك أو لدى سُخص 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
Arabic	كنت لا تملك بطاقة، فاتصل على 6984-710-855.
မွနျမာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးစွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ပင်ကဒ်၏ နောက်ကျောဖက်ပေါ်ရှိ သုံးစွဲသူ ပန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ပင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။
GWY	ԽՅΖ, D& YGT Ə ԹՅՏՔℬℇУ, ՆՅՐՐՆՆՅՆ, ԽՅ ՇԺ ƏℬУ RCPℛՏጓቭ D& RCZ4ቭ CH ՇՕՆԽՅℬቭ EW®Y D4∿℃. ƏℬYZ DЛРЛℬУ ՇℬԼ&Z₽ЛТ, ФԽℬЬѠՐЪ ƏℬYƏT O'ՒGℬY
Cherokee	DƏLℬՏℙℬሃ ƏℬY PPT ՇՄℙ ՃቭՐ DILℎ℻⅄ Տ⅄ՋՉՂT Л4ℬቭ. ЛРӘ ԽԽRƏ ՃУ, D& DILℎ℻⅄ ℎՇ℗℈ ՃУ, ՓℬԵѠՐՖ DԺԽ 855-710-6984.
繁體中文	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
Chinese	會員卡, 請致電 855-710-6984。
Français	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
French	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.
Hmoob	Yog koj, los yog tej tus neeg uas koj pab ntawd muaj lus nug txog, koj muaj cai hais kom lawv pab muab cov ntaub ntawv sau ua koj hom lus pub dawb rau koj. Xav tham nrog ib tug kws txhais lus, hu rau tus nab
Hmong	npawb xovtooj pab cuam neeg qhua uas nyob sab tom qab ntawm koj daim npav tswv cuab. Yog koj tsis yog ib tug neeg tswv cuab, los yog koj tsis muaj npav, hu rau 855-710-6984.
한국어	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
Korean	번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ	ຖ້າທ່ານ ຫຼື ຄົນທີທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍມີຄ່າ
Laotian	ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເປີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, čí 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'i' hadeesdzih nínízingo čí kwe'ć da'íníishgi áká anídaalwo'ígíí bich'i' hodíílnih, bee nčćhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'čégóó čí doodago bee nčéhózinígíí ádingo koji' hodíílnih 855-710-6984.
فارسی	اگر شما، پاکسی 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 خدمات مشتری به شماره ای که در یشت کارت عضویت شما
Persian	درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 6984-710-855 تماس حاصل نمایید.
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.
ใทย	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย
Thai	พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
اردو	گر آپ کو، پا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں منت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے
Urdu	کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، پا آپ کے پاس کارڈ نہیں ہے تو، 1966-710۔855 پر کال کریں۔
Tiếng Việt	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
Vietnamese	hàng nằm ở phía sau thể hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thể, 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 h	If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.					
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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		800-368-1019 800-537-7697 <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u> <u>http://www.hhs.gov/ocr/office/file/index.html</u>				