



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsmt.com or by calling 1-855-258-3489.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$500 person/ \$1,500 family Doesn't apply to first \$250 diabetic education, home health, hospice, mammograms, second surgical opinions, preventive health, and well-child. Coinsurance doesn't count toward the deductible.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$25 for dental services. There are no other specific <u>deductibles</u> .	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.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$2,000 person/ \$6,000 family for medical and \$1,650 person/ \$3,300 family for prescription drugs	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Prescription Drug Program deductible, copayments and/or coinsurance, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.bcbsmt.com or call 1-855-258-3489 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

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Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	---None---
	Specialist visit	20% coinsurance	30% coinsurance	---None---
	Other practitioner office visit	20% coinsurance	30% coinsurance	\$30 maximum paid per visit for chiropractic treatments.
	Preventive care/screening/immunization	No charge	No charge	One breast pump per birth event
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	---None---

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Yellowstone County: CMM

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/14 – 06/30/15

Coverage for: Family Membership | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.urxpharmacy.org.</p>	Prescription Drugs – Benefit information can be obtained by contacting URx visiting www.urxpharmacy.org	Deductible applies, then copayments, except for preventive	Not covered	---None---
	Preventive Drugs	Refer to the URx Pharmacy Benefit Administrator (toll free 888-648-6764) for specific copayment information	Not covered	Certain preventive medications have a first dollar benefit. No deductible applies. Limited to a 30-day supply through retail pharmacy and 90 day supply through mail order.
	Tier A	\$0 copayment after deductible (retail pharmacy and mail order)	100% coinsurance	Limited to a 30-day supply through retail pharmacy and 90 day supply through mail order. Tier A, Tier B and Tier C drugs, for both retail and mail order will be subject to a prescription drug out-of-pocket limit of \$1,650 single coverage or \$3,300 family coverage per calendar year.
	Tier B	\$15 copayment after deductible (retail pharmacy) and \$30 copayment after deductible (mail order)	100% coinsurance	
	Tier C	\$40 copayment after deductible (retail pharmacy) and \$80 copayment after deductible (mail order)	100% coinsurance	
	Tier D	50% coinsurance after deductible (retail pharmacy and mail order)	100% coinsurance	

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	Tier F	100% coinsurance	100% coinsurance	Tier F medications do not apply to the medical or prescription drug out of pocket limit.
	Tier S	The URx specialty program offers a variety of preferred drugs at \$50 copayment, other specialty meds will have a \$200 copayment.	100% coinsurance	---none---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	---None---
	Physician/surgeon fees	20% coinsurance	30% coinsurance	---None---
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	---None---
	Emergency medical transportation	20% coinsurance	20% coinsurance	---None---
	Urgent care	20% coinsurance	30% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Maximum of \$25,000 for transplant organ procedure and \$10,000 for ambulance or commercial air travel, per transplant.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	---None---

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	---None---
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	---None---
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	---None---
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	---None---
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance	---None---
	Delivery and all inpatient services	20% coinsurance	30% coinsurance	---None---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	100 visit maximum per benefit period.
	Rehabilitation services	20% coinsurance	30% coinsurance	---None---
	Habilitation services	20% coinsurance	30% coinsurance	No Applied Behavior Analysis (ABA) benefits for Autism Spectrum Disorder available for members 19 years of age or older.
	Skilled nursing care	20% coinsurance	20% coinsurance	90 days maximum per benefit period.
	Durable medical equipment	20% coinsurance	20% coinsurance	---None---
	Hospice service	No charge	No charge	---None---
If your child needs dental or eye care	Eye exam	Not covered	Not covered	---None---
	Glasses	Not covered	Not covered	---None---
	Dental check-up	20% coinsurance	20% coinsurance	Maximum of \$3,000 per benefit for all dental services.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (with the exception of person with co-morbidities, such as diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Dental care (Adult)(Maximum of \$3000 per benefit for all covered services)
- Most coverage provided outside the United States. See www.bcbsmt.com.
- Non-emergency care when traveling outside the U.S.

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.

For more information on your rights to continue coverage, contact the plan at 1-855-258-3489. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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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 questions about your rights, this notice, or assistance, you can contact: Blue Cross and Blue Shield of Montana at 1-855-258-3489, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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 <http://www.csi.mt.gov>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as a minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

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, kwijigo holne' 1-855-258-3489.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$5,520**
- **Patient pays \$2,020**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Copays	\$20
Coinsurance	\$1,350
Limits or exclusions	\$150
Total	\$2,020

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,000**
- **Patient pays \$1,400**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$500
Copays	\$380
Coinsurance	\$440
Limits or exclusions	\$80
Total	\$1,400

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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