Blue Preferred Silver PPO℠ 101 - Three $0 PCP Visits

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

Coverage for: Individual/Family | Plan Type: PPO

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/pdf/policy-forms/30751MT0550010-01.pdf or by calling 1-855-258-8471.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** person/**$6,000** family In-Network **$12,000** person/**$24,000** family Out-of-Network Doesn't apply to diabetic education, prescription drugs, first three In-Network PCP office visits, In-Network mental health/ substance use disorder office visits, In-Network hospice, In-Network routine/diagnostic mammograms, the first $70 for out-of-network routine mammograms, In-Network preventive health, and well-child. Coinsurance and per occurrence deductibles don't count toward the overall deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. ER **$600**; Inpatient **$400/ $1,500**; Outpatient Surgery **$300/$1,500**. There are no other specific **deductibles**.	You must pay all the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. **$6,600** person/**$13,200** family In-Network **$26,400** person/**$52,800** family Out-of-Network	The **out-of-pocket** limit 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 out-of-pocket limit?	Premiums, balance-billed charges, 50% benefit reduction for prescription drugs purchased at a Non-Participating pharmacy and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Questions: Call **1-855-258-8471** or visit us at www.bcbsmt.com/coverage.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-258-8471 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See www.bcbsmt.com **or call 1-855-258-8471** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** 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 6. See your policy or plan document for additional information about **excluded services**.

- **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 health 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.**)
- The plan may encourage you to use In-Network **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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	No charge for the first three In-Network office visits; deductible and coinsurance apply for subsequent visits.
	Specialist visit	20% coinsurance	50% coinsurance	---none---
	Other practitioner office visit	20% coinsurnace	50% coinsurance	10 visit maximum per benefit period for chiropractic treatments. 12 visit maximum per benefit period for acupuncture treatments.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Maximum of two electric breast pumps per year. Deductible and coinsurance do not apply to the payment of the first $70 for out-of-network routine mammograms. Deductible does not apply to out-of-network well child services.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	---none---
	Imaging (CT / PET scans, MRIs)	20% coinsurance	50% coinsurance	

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 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/IVL/2016/2016_MT_5T_EX.pdf.	Preferred generic	Retail – No Charge/ $5 Mail – No Charge	Retail – $5 plus an additional 50% of the Average Wholesale Price (AWP)	Lower copay applies at Value Participating pharmacies. Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription – in-network only). 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. Specialty drugs covered up to a 30-day supply.
	Non-preferred generic	Retail – $10/$15 Mail – $30	Retail – $15 plus an additional 50% of the AWP	
	Preferred brand-name (Formulary)	Retail – $50/$60 Mail – $150	Retail – $60 plus an additional 50% of the AWP	
	Non-preferred brand-name (Non-Formulary)	Retail – $100/$110 Mail – $300	Retail – $110 plus an additional 50% of the AWP	
	Specialty pharmaceuticals	$250 copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 per occurrence deductible plus 20% coinsurance	$1,500 per occurrence deductible plus 50% coinsurance	Per occurrence deductible is in addition to the overall deductible and coinsurance. Abortion is not covered except in limited circumstances. Failure to preauthorize prior to service, 15 days for In-Network or 2 days for Out-of-network, may result in claim denial.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	$600 per occurrence deductible plus 20% coinsurance	$600 per occurrence deductible plus 20% coinsurance	Per occurrence deductible is in addition to the overall deductible and coinsurance; waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	$75 copay/visit	$75 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 per occurrence deductible plus 20% coinsurance	$1,500 per occurrence deductible plus 50% coinsurance	Per occurrence deductible is in addition to the overall deductible and coinsurance. Failure to preauthorize prior to admission may result in claim denial.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	---none---

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge for office visits or 20% coinsurance for other outpatient services	50% coinsurance	Outpatient: Preauthorization required for psychological testing, neuropsychological testing, electroconvulsive therapy, repetitive transcranial magnetic stimulation, and intensive outpatient treatment. Failure to preauthorize prior to service, 15 days for In-Network or 2 days for Out-of-network, may result in claim denial. Inpatient: Per occurrence deductible is in addition to the overall deductible and coinsurance. Residential treatment facilities will be covered if medical necessity criteria are met. Failure to preauthorize prior to admission may result in claim denial.
	Mental/Behavioral health inpatient services	$400 per occurrence deductible plus 20% coinsurance	$1,500 per occurrence deductible plus 50% coinsurance	
	Substance use disorder outpatient services	No Charge for office visits or 20% coinsurance for other outpatient services	50% coinsurance	
	Substance use disorder inpatient services	$400 per occurrence deductible plus 20% coinsurance	$1,500 per occurrence deductible plus 50% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	---none---
	Delivery and all inpatient services	$400 per occurrence deductible plus 20% coinsurance	$1,500 per occurrence deductible plus 50% coinsurance	Per occurrence deductible is in addition to the overall deductible and coinsurance.

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 need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	180 visit maximum per benefit period. Failure to preauthorize prior to service, 15 days for In-Network or 2 days for Out-of-network, may result in claim denial.
	Rehabilitation services	20% coinsurance	50% coinsurance	Includes physical, occupational and speech therapy.
	Habilitation services	20% coinsurance	50% 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	50% coinsurance	60 days maximum per benefit period. Failure to preauthorize prior to admission may result in claim denial.
	Durable medical equipment	20% coinsurance	50% coinsurance	---none---
	Hospice service	No Charge	50% coinsurance	Failure to preauthorize prior to admission may result in claim denial.
If your child needs dental or eye care	Eye exam	No Charge	No Charge	One exam per benefit period for children under age 19.
	Glasses	20% coinsurance	50% coinsurance	One pair of glasses per benefit period for children under age 19.
	Dental check-up	Not Covered	Not Covered	---none---

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.)

- Abortions (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
- 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

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 (12 visit maximum per benefit period) • Chiropractic care (10 visit maximum per benefit period)	• Cosmetic surgery (Only for the correction of a condition resulting from an accident, a condition resulting from an injury or to treat a congenital anomaly)	• Infertility treatment (With the exception of in vitro fertilization and prescription medications)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-8471. You may also contact your state insurance department at **http://www.csi.mt.gov/industry/insurance.asp**.

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 1-800-447-7828, 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 or policy does provide minimum essential coverage.**

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 page.

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 the plan. The actual care you receive will be different from these examples, and the cost of that care also will 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** $2,940
- **Patient pays** $4,600

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	$3,700
Copays	$0
Coinsurance	$700
Limits or exclusions	$200
Total	**$4,600**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,920
- **Patient pays** $2,480

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	$2,400
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,480**

Questions and answers about 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.