Blue Cross Blue Shield: MUS Employee Benefit Plan

Coverage Period: 07/01/2016 – 06/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee/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.choices.mus.edu or by calling 1-877-501-1722.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750/person In-Network** **$1,500/family In-Network** Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Deductible applies to all services, unless otherwise indicated, or a copayment applies.
Are there other deductibles for specific services?	**$750/person Out-of-Network** **$1,750/family Out-of-Network**	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. There is a separate deductible for out of-network services. You may be responsible for balance billing. These amounts do not apply to your out-of-pocket expenses.
Is there an out–of–pocket limit on my expenses?	**$4,000/person In-Network** **$8,000/family In-Network** **$6,000/person Out-of-Network** **$12,000/family Out-of-Network**	The **out-of-pocket limit** is the most you could pay during a coverage period for your share of the cost of covered services. This limit helps you plan for health care expenses. In-Network maximum out-of-pocket amount – includes deductible, coinsurance, and copayments. Out-of-Network – a separate out-of-pocket amount, which includes deductible, coinsurance, and copayments.
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**.
Is there an overall annual limit on what the plan pays?	No.	There may be day limits or visit limits on some services, but no overall annual dollar limit.
Does this plan use a network of providers?	Yes. See www.bcbsmt.com/find-a-doctor-or-hospital or call 1-800-820-1674 for a list of network participating providers.	If you use an In-Network **provider**, this plan will pay some or all of the costs of covered services. Be aware, your In-Network provider may use an Out-of-Network **provider** for some services. Plans use the term In-Network, **preferred**, or participating for **providers** in their **network**.

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 **excluded services** this plan doesn't cover are listed on page 5. See "Exclusions" in the Summary Plan Description (SPD).

- **Copayments** are fixed dollar amounts (for example, $25/$40) 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 25% would be $250. 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 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 Provider (PCP) visit to treat an injury or illness, includes Naturopathic	$25 copay/visit	35% coinsurance	Office visit limited to evaluation and management charges. All other charges are subject to deductible and coinsurance. Naturopathic services- You may be responsible for balance billing.
	Specialist visit	$40 copay/visit	35% coinsurance	Office visit limited to evaluation and management charges. All other charges are subject to 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
	Outpatient rehabilitative services visit- physical, speech, occupational, pulmonary, cardiac, and respiratory therapies, acupuncture, and chiropractic	$25 copay/visit	35% coinsurance	Max 30 visits- all rehabilitative therapies combined. Acupuncture services- You may be responsible for balance billing.
	Preventive care/screening/immunization	0%	35% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	35% coinsurance	
	Imaging (CT/PET scans, MRIs)	25% coinsurance	35% coinsurance	May require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.urx.mus.edu.	Generic Drugs- TIER A	**Retail** $0 copay	**Mail-Order** $0 copay	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred Brand Drugs- TIER B	$25 copay	$50 copay	
	Non-preferred Brand Drugs- TIER C TIER D TIER F	$60 copay 50% coinsurance 100% coinsurance	$120 copay 50% coinsurance 100% coinsurance	50% of discounted price 100% of discounted price
	Specialty drugs- TIER S	$150 or $300 copay	Not covered	50% coinsurance- standard retail pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	35% coinsurance	
	Physician/surgeon fees	25% coinsurance	35% coinsurance	
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	All other charges are subject to deductible and coinsurance.
	Emergency medical transportation	$200 copay/ transport	$200 copay/ transport	
	Urgent care	$75 copay/visit	$75 copay/visit	Office visit limited to evaluation and management charges. All other charges are subject to 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 have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	35% coinsurance	
	Physician/surgeon fee	25% coinsurance	35% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	1st 4 at $0, then $25 copay/visit	35% coinsurance	1st 4 $0 copay visits are combined with substance abuse disorder visits.
	Mental/Behavioral health inpatient services	25% coinsurance	35% coinsurance	
	Substance use disorder outpatient services	1st 4 at $0, then $25 copay/visit	35% coinsurance	1st 4 $0 copay visits are combined with mental/behavioral health visits.
	Substance use disorder inpatient services	25% coinsurance	35% coinsurance	
If you are pregnant	Prenatal and postnatal care	25% coinsurance	35% coinsurance	
	Delivery and all inpatient services	25% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Home health care	$25 copay/visit	35% coinsurance	Needs prior authorization/max 30 visits/year.
	Inpatient rehabilitative services	25% coinsurance	35% coinsurance	30 days/year
	Skilled nursing care	25% coinsurance	35% coinsurance	Needs prior authorization/max 30 visits/year.
	Durable medical equipment	25% coinsurance	35% coinsurance	
	Hospice service	25% coinsurance	35% coinsurance	Maximum is 6 months.
If you need dental or eye care	Eye exam **covered by medical plan	0% - one/year	35% - one/year	Limited to one exam per year
	Optional vision hardware ** BCBSMT			Up to $300- frames and lenses or $150- contact lenses per year
	Dental check-up ** Delta Dental			Fee schedule payment. Covers up to $750/individual (Basic plan) /$1,500/individual (Select plan)

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.)

- Cosmetic surgery
- Routine foot care
- Work related accident or illness
- Hearing aids
- Infertility treatment
- Private duty nursing

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.)

- Organ transplant
- Acupuncture services
- Preventive services
- Chiropractic care
- Medically necessary travel with prior authorization- $1,500 max/year

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.

You can keep this coverage as long as your premiums are paid, unless your employment terminates, or hours worked drop below 20. If you have no other coverage, you can choose to keep this coverage by electing COBRA (Consolidated Omnibus Budget Reconciliation Act). See your campus HR office for rules regarding election of COBRA benefits, and making premium payments.

For more information on your rights to continue coverage, contact the plan at 1-877-501-1722.

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 Blue Shield of Montana at 1-800-820-1674 or MUS Employee Benefits at 1-877-501-1722.

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.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 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:** $7,500
- **Plan pays** $5,072.50 + Rx charges
- **Patient pays** $2,427.50 + Rx charges

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$150
Radiology	$200
Vaccines, other preventive	$50
Total	**$7,500**

Patient pays:

Deductibles	$750
Copays	$0
Coinsurance	$1,677.50
Limits or exclusions	$0
Total	**$2,427.50**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $2,420 + Rx charges
- **Patient pays** $1,680 + Rx charges

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$750
Copays	$200
Coinsurance	$730
Limits or exclusions	$0
Total	**$1,680**

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.