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**	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**	There is a separate deductible for out of-network services.
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**	In-Network maximum out-of-pocket amount – includes deductible, coinsurance, and copayments Out-of-Network – a separate out-of-pocket amount, includes deductible, coinsurance, and copayments
What is not included in the out–of–pocket limit?	non-covered services, and balance billing	Even though you pay these expenses, they are not included in 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 to find a network provider.
Do I need a referral to see a specialist?	No	The deductible and coinsurance are higher if you choose an out-of-network specialist.
Are there services this plan doesn't cover?	Yes	See "Exclusions" in the Summary Plan Description (SPD)

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- **Co-payments** are fixed dollar amounts (for example, $25/$40) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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/or **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	$25 copayment	35%	
	Specialist visit	$40 copayment	35%	
	Other practitioner visit- acupuncture/ naturopathic, chiropractic, massage therapy	$25 copayment	35%- chiropractic only	Max 30 visits- except naturopathic, no visit limit You may be responsible for balance billing
	Preventive care/screening/immunization	0%, no deductible	35%	
If you have a test	Diagnostic test (x-ray, blood work)	25%	35%	
	Imaging (CT/PET scans, MRIs)	25%	35%	May require prior authorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** in www.urx.mus.edu	**URx**	**Retail (30 days)**	**Mail-Order (90 days)**	
	Generic Drugs- TIER A	$0 copay	$0 copay	
	Preferred Brand Drugs- TIER B	$25 copay	$50 copay	
	Non-preferred Brand Drugs- TIER C	$60 copay	$120 copay	
	TIER D	50% coinsurance	50% coinsurance	50% of discounted price
	TIER F	100% coinsurance	100% coinsurance	100% of discounted price
	Specialty drugs (see work book)- TIER S	$150 or $300 copay	Not covered	50% coinsurance- retail pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery) center)	25%	35%	
	Physician/surgeon fees	25%	35%	

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 immediate medical attention	Emergency medical transportation	$200 copayment	$200 copayment	
	Emergency room services	$250 copayment/visit	$250 copayment/visit	All other charges- deductible & coinsurance apply
	Urgent care	$75 copayment/visit	$75 copayment/visit	All other charges- deductible & coinsurance apply
If you have a hospital stay	Facility fee (e.g., hospital room)	25%	35%	
	Physician/surgeon fee	25%	35%	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	1st 4 at $0, then $25	35%	
	Mental/Behavioral health inpatient services	25%	35%	
	Substance use disorder outpatient services	1st 4 at $0, then $25	35%	
	Substance use disorder inpatient services	25%	35%	
If you are pregnant	Prenatal and postnatal care	25%	35%	
	Delivery and all inpatient services	25%	35%	
If you need help recovering or have other special health needs	Home health care	$25 copayment/visit	35%	Needs prior auth/max 30 visits/yr
	Rehabilitation services- inpatient/outpatient	25% inpatient	35%	Inpatient- 30 days/yr
		$25 copay outpatient		Outpatient- 30 days/yr
	Skilled nursing care	25%	35%	30 days/yr – needs prior authorization
	Durable medical equipment	25%	35%	
	Hospice service	25%	25%	Maximum is 6 months
If your child needs dental or eye care	Eye exam **covered by Health Plan Glasses **optional vision hardware- BCBS	0% - one/year	35% - one/year	See Choices book for allowances
	Dental check-up ** Delta Dental			Fee schedule payment

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.)

- work related accident or illness
- cosmetic procedures
- infertility treatment

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
- preventive services
- medically necessary travel with prior authorization- $1,500 max/yr.

Your Rights to Continue Coverage:

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. See your HR office for rules regarding election of COBRA benefits, and making premium payments.

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 EB at 1-877-501-1722.

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:** $7,540
- **Plan pays** $4,912.50 + Rx drugs
- **Patient pays** $2,387.50 + Rx copays

Sample care costs: $7,540

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

Patient pays:

Deductibles	$750
Co-pays	$
Co-insurance	$1,637.50
Limits or exclusions	$
Total	**$2,387.50**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $1477.50 + Rx drugs
- **Patient pays** $1,122.50 + Rx copays

Sample care costs: $4,100

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits (8)	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$750
Co-pays (OV copayments 8 x $25)	$200
Co-insurance	$172.50
Limits or exclusions	$
Total	**$1,122.50**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.