

Build Your Benefits

Outline of Coverage

First...

1

Choose your **Individual Deductible and Out-of-Pocket Maximum**

Deductible / Out-of-Pocket Maximum

- \$1,250/\$7,500
- \$2,500/\$7,500
- \$5,000/\$7,500
- \$1,250/\$10,000
- \$2,500/\$10,000
- \$5,000/\$10,000
- \$10,000/\$15,000

Next...

2

Choose your **Co-insurance**

In Network / Out of Network

- 60/40
- 70/30
- 80/20
- 50/50
- 60/40
- 70/30

Finally...

3

Choose your **Primary Care Services Benefit**

- \$0
- \$275
- \$450
- \$750

If more than one person is covered by the same contract, family deductibles and out-of-pocket amounts are two times the amount shown above for individuals. Any amount you pay for balances owed to nonparticipating providers and prescriptions does not apply to the out-of-pocket amount.

Key Things to Remember About Your Benefits

- **Lifetime Maximum**—Benefit \$5,000,000
- **Benefit Period**—Calendar Year (January 1 through December 31)
- **Deductible Waived For**—Primary Care Services Benefit (if selected), Diabetic Education, Well-Child Care, Mammograms (up to the first \$70)
- **Primary Care Services Benefit**— The Primary Care Services Benefit covers home and office calls when services are provided by a Participating Professional Provider. Covered services pay at 100% until the Primary Care Services Benefit maximum is reached. Services include: Office calls, any services and supplies provided during the office call; Physical examinations; Vision examinations; Gynecological examinations, including routine PAP smears; Immunizations and vaccinations not covered under the Well-Child Care benefit; Diagnostic X-ray and laboratory services; Services which are provided for the treatment of an accident, if provided in a Participating Professional Provider's office. After your Primary Care Services Benefit limit is reached, your annual deductible and co-insurance apply to covered services. If Primary Care Services are provided by a nonparticipating professional provider, deductible and co-insurance apply.

Key Things to Remember About Your Networks

- **Preferred Provider Organization (PPO)**— When you receive inpatient or outpatient services from a HealthLink PPO Network hospital or surgery center, you receive the most value from your health care benefits while limiting your out-of-pocket expenses.
- **Locate Participating Providers and HealthLink PPO hospitals and surgery centers in Montana**—Visit the BCBSMT website at www.bcbsmt.com or call Customer Service at 1-800-447-7828.
- **Nationwide networks at your fingertips**—With BlueCard, you have access to Participating Providers and PPO providers across the country. Visit the BlueCross and BlueShield Association website at www.bcbs.com/healthtravel/ or call 1-800-810-BLUE.
- **Balance Billing**— Out-of-Network providers can bill you the difference between the allowable fee and their total charge, plus any deductible and co-insurance, potentially making your out-of-pocket expenses significantly higher.

To learn more about Blue Evolution, call Blue Cross and Blue Shield of Montana at 1-800-447-7828, contact your local BCBSMT agent, or visit our website at www.bcbsmt.com.

Benefit Highlights *(for more detailed information, refer to your Contract)*

Deductible applies to all services listed below, unless otherwise indicated.

Prior Authorization, which is not a guarantee of payment, is recommended for some services, supplies, treatments and drugs to help the member identify potential expenses, payment reductions, or claim denials the Member may have if these proposed services, etc. are not Medically Necessary or not a Covered Medical Expense. Examples of such services are: Hospice, TMJ surgery and Durable Medical Equipment over \$500. Refer to your Contract.

Benefit	Covered Services
Professional Provider Services	Home and office calls, surgery, anesthesia, diagnostic lab and X-ray, and maternity services.
Inpatient Hospital	Room and board, special care units, ancillary charges and transplant coverage.
Outpatient Hospital	Accidental injury, X-ray and lab, surgery, chemotherapy, respiratory therapy, radiation therapy, medical emergency, surgery center, blood transfusion services, ambulance, and orthopedic devices. Any services provided in an emergency room are not covered under your Primary Care Services Benefit.
Individual Therapies	Physical, occupational, speech and cardiac rehabilitation therapies. \$2,000 maximum per benefit period, combined for outpatient professional and facility charges.
Rehabilitation Therapy	\$100,000 lifetime maximum, per member, for inpatient and outpatient therapy services.
Chiropractic Services	Not Covered.
Durable Medical Equipment and Prostheses	Initial purchase, replacements and repair. Prior Authorization is recommended if charges are over \$500.
Mental Illness	<i>Note: Severe Mental Illness is processed under regular medical benefits.</i>
Outpatient	\$2,000 maximum per benefit period.
Inpatient	21 days for professional, hospital and/or freestanding inpatient facility charges, per benefit period combined with chemical dependency. Inpatient day maximum applies. Plan notification is recommended.
Autism Spectrum Disorder	Diagnosis and treatment of Autistic disorder, Asperger's disorder or pervasive developmental disorder. Habilitative or rehabilitative care, including, but not limited to, professional, counseling and guidance services and treatment programs; Applied Behavior Analysis (ABA), also known as Lovaas therapy; discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention; medications; psychiatric or psychological care; therapeutic care provided by a speech-language pathologist, audiologist, occupational therapist or physical therapist. The following maximums apply: \$50,000 a year for a child 8 years of age or younger; \$20,000 a year for a child 9 years of age through 18 years of age.
Chemical Dependency	\$1,000 per 12 months for outpatient services. 21 days for professional and/or freestanding inpatient facility charges, per member, per benefit period, combined with Mental Illness. \$4,000 maximum benefit per benefit period. \$8,000 lifetime maximum benefit.
Well-Child Care*	Well-child exams, lab tests and immunizations through seven years of age.
Mammograms	Paid at 100% of the actual charge, up to a maximum of \$70. Deductible and coinsurance apply to any balance after the first \$70 is paid.
Diabetic Education Benefit*	Up to \$250 per benefit period for outpatient services.
Prescription Drug Card Program	Generics only. \$100 drug deductible, \$5 copay, \$2500 annual maximum benefit. You may also use your Prescription Drug Card to obtain discounted pricing when you purchase non-covered prescriptions.
Ambulance	Processed under regular medical benefits.

* Deductible does not apply.

This information is only a summary of benefits. Benefits, limitations, and general provisions described herein are subject to the terms of the Contract.