Montana Credit Union Benefits Plan: Diamond PPO Plan

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee & Dependent | **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.mcun.coop/group_benefits or by calling 1-866-268-3622.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** per person **/ $2,000** family. Does not apply to physician fees, non-routine colonoscopy up to $1,200, mammograms, hospice care, preventive care, and network skilled nursing. Prescription coinsurance/ copayment don't count toward the 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 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,000** per person **/ $2,000** family for covered medical benefits. **$1,650** per person **/ $3,300** family for covered prescription drug benefits.	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?	Prescription coinsurance/ copayments, premiums, balance-billed charges (unless balanced billing is prohibited), 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.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.ebms.com or call 1-866-268-3622.	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 2 for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No.	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 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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-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% coinsurance	35% coinsurance	*none*
	Specialist visit	25% coinsurance	35% coinsurance	*none*
	Other practitioner office visit	25% co-insurance for chiropractor	35% coinsurance for chiropractor	Coverage is limited to $600 for chiropractor treatments per calendar year max.
	Preventive care/screening/immunization	No charge	No charge	Coverage is limited to age and developmentally appropriate frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	35% coinsurance	*none*
	Imaging (CT/PET scans, MRIs)	25% coinsurance	35% coinsurance	*none*

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **Administered through URx.** More information about **prescription drug coverage** is available at www.mcun.coop/group_benefits or calling 1-888-648-6764	Tier A drugs	0% coinsurance	Reimbursed up to the allowable participating pharmacy amount	Coverage is limited to a 30-day supply through retail pharmacy and 90-day supply through mail order. Coverage of Tier A, Tier B and Tier C drugs will be subject to the prescription drug out-of-pocket limit at both retail pharmacy and mail order.
	Tier B drugs	$15/prescription retail $30/prescription mail order		
	Tier C drugs	$40/prescription retail $80/prescription mail order		
	Tier D drugs	50% coinsurance		Coverage is limited to a 30-day supply through retail pharmacy and 90-day supply through mail order. Tier D medications do not apply to the medical or prescription drug out of-pocket limits.
	Tier F drugs	100% coinsurance		Coverage is limited to a 30-day supply through retail pharmacy and 90-day supply through mail order.
	Tier S drugs	Refer to the Pharmacy Benefit Administrator (URx)	Not Covered	Coverage is limited to specialty medication. Contact Pharmacy Benefit Administrator (URx) for specific copayment information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	35% coinsurance	*none*
	Physician/surgeon fees	25% coinsurance	35% coinsurance	*none*
If you need immediate medical attention	Emergency room services	25% coinsurance	25% coinsurance	*none*
	Emergency medical transportation	25% coinsurance	25% coinsurance	*none*
	Urgent care	25% coinsurance	35% coinsurance	*none*

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	35% coinsurance	Pre-notification is recommended.
	Physician/surgeon fee	25% coinsurance	35% coinsurance	Pre-notification is recommended.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% coinsurance	35% coinsurance	*none*
	Mental/Behavioral health inpatient services	25% coinsurance	35% coinsurance	Pre-notification is recommended.
	Substance use disorder outpatient services	25% coinsurance	35% coinsurance	*none*
	Substance use disorder inpatient services	25% coinsurance	35% coinsurance	Pre-notification is recommended.
If you are pregnant	Prenatal and postnatal care	25% coinsurance	35% coinsurance	*none*
	Delivery and all inpatient services	25% coinsurance	35% coinsurance	Pre-notification is recommended.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	35% coinsurance	Coverage is limited to 180 visits per calendar year max.
	Rehabilitation services	25% coinsurance	35% coinsurance	*none*
	Habilitation services	25% coinsurance	35% coinsurance	
	Skilled nursing care	25% coinsurance	35% coinsurance	Coverage is limited to 60 visits per calendar year max.
	Durable medical equipment	25% coinsurance	35% coinsurance	*none*
	Hospice service	No charge	No charge	Coverage is limited to 185 inpatient days and outpatient visits per lifetime max.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge	No charge up to $46	Coverage is limited to 1 exam per 12 months. Benefits are provided by Vision Service Plan.
	Glasses	100% after 20% discount	Not covered	Coverage is limited to 1 complete pair of glasses per 12 months.
	Dental check-up	No charge	No charge	Coverage is limited to 2 exams and cleaning per calendar year max.

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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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.)**

- Chiropractic care
- Dental care (Adult)
- Routine eye care (Adult)

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 406-761-2820. 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.

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: Employee Benefits Management Services, Inc. (EBMS) at 1-800-777-3575 or www.ebms.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html.

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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 866-268-3622.

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** $6,350
- **Patient pays** $1,140

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	$1,000
Copays	$40
Coinsurance	$2,380
Limits or exclusions	$150
Total	**$1,190**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $1,080

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	$1,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,080**

HHS COVERAGE EXAMPLE CALCULATOR

- *This Plan has elected to use the U. S. Department of Health and Human Services (HHS) coverage calculator for the second year of applicability. These coverage examples are not an accurate reflection of the benefits under your plan. The calculator is available at http://www.dol.gov/ebsa/healthreform/*

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.

Questions: Call 1-866-268-3622 or visit us at www.mcun.coop/group_benefits.
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/healthreform or call 1-866-487-2365 to request a copy.

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