

**MONTANA
NONPROFIT
ASSOCIATION
(MNA)**

**BLUE CROSS AND BLUE SHIELD OF MONTANA
GUIDE TO BENEFIT PLAN OPTIONS**

July 1, 2009

Plan Options

Introduction

This brochure is a guide to the benefit plan options available to the Montana Nonprofit Association. These benefit plans are underwritten by Blue Cross and Blue Shield of Montana.

Note: This material is presented as general information only. The content is not to be accepted as a substitute for the provisions of the master policies.

Benefit Period

The benefit period is July 1 through June 30.

Medical Plan Options

The table below describes the **medical plan options**:

Plan	Medical Plan Options
Option 1 CMM PPO 50/50	<ul style="list-style-type: none"> • \$1,000 Individual Deductible/\$2,000 Family Deductible. • \$3,000 Individual Out-of-Pocket Amount/\$6,000 Family Out-of-Pocket Amount. \$100 Preventive Benefit. • 50/50 Coinsurance. • \$400 Drug Deductible per member, Drug Copayments \$8/\$25/25%.
Option 2 CMM PPO 50/50	<ul style="list-style-type: none"> • \$1,500 Individual Deductible/\$3,000 Family Deductible • \$4,500 Individual Out-of-Pocket Amount/\$9,000 Family Out-of-Pocket Amount. \$100 Preventive Benefit • 50/50 Coinsurance • \$400 Drug Deductible per member, Drug Copayments \$8/\$25/25%
Option 3 Big Sky Select 70/30	<ul style="list-style-type: none"> • Level A - No deductible • Level B - \$750 Individual/\$1,500 Family Deductible • Level C - \$1,500 Individual/\$3,000 Family Deductible • \$2,000 Individual Out-of-Pocket Amount, \$4,000 Family Out-of-Pocket Amount • Level A - \$30 Office Visit • Levels B & C - 70/30 • \$100 Drug Deductible per member. Drug Copayments \$8/\$15/\$30.
Option 4 Health First PPO 50/50	<ul style="list-style-type: none"> • \$500 Individual Deductible/\$1,000 Family Deductible • \$2,000 Individual Out-of-Pocket Amount/\$4,000 Family Out-of-Pocket Amount. \$100 Preventive Benefit, \$300 Supplemental Accident Benefit • 50/50 Copayment • \$100 Drug Deductible. Drug Copayments \$8/\$15/\$30

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Plan Options, Continued

Plan	Medical Plan Options
Option 5 CMM HSA PPO 100/0	<ul style="list-style-type: none"> • \$3,000 Individual Deductible/\$6,000 Family Deductible • \$3,000 Individual Out-of-Pocket Amount/\$6,000 Family Out-of-Pocket Amount. \$100 Preventive Benefit. • 100/0 Copayment • Prescriptions process under medical benefits.
**Option 6 CMM HSA PPO 100/0	<ul style="list-style-type: none"> • \$4,800 Individual Deductible/\$9,600 Family Deductible • \$4,800 Individual Out-of-Pocket Amount/\$9,600 Family Out-of-Pocket Amount. \$100 Preventive Benefit. • 100/0 Copayment • Prescriptions process under medical benefits.
**Option 7 CMM PPO 50/50	<ul style="list-style-type: none"> • \$4,000 Individual Deductible/\$8,000 Family Deductible • \$8,000 Individual Out-of-Pocket Amount/\$16,000 Family Out-of-Pocket Amount. \$250 First dollar benefit. • 50/50 Copayment • Prescriptions process under medical benefits. • \$100,000 Annual Maximum • \$250,000 Lifetime Maximum

*See the “Participating Provider Networks” section for an explanation of Levels A, B, and C.

** An employer group with one sole employee is eligible for benefit Option 6 and 7 only

Montana HealthLink Hospital Network (PPO)

Montana HealthLink is a health benefit program developed by Blue Cross and Blue Shield of Montana and Preferred Hospital Providers to offer health care services at lower premiums to you. You agree to use the Preferred Hospital Providers whenever you need hospital services. (See agent for hospital list.)

It is very important you and your employees understand services received outside the HealthLink PPO Network may result in significantly less benefit payment and increased out-of-pocket expenses.

Deductible

The deductible is the amount you have to pay for covered services provided during a benefit period before payment is made for covered services. Plan A contains a provision that allows any deductible applied for services you received in April, May, and June of one year to carry forward and be applied to the next year’s deductible. There is **no deductible** for some services. Please refer to the Comparison of Benefits Summary.

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Plan Options, Continued

Copayment

The copayment is the member's share of the allowable fee for covered services. The copayment varies by plan option. Please refer to the Comparison of Benefits Summary for the copayment for each plan.

Out-of-Pocket Amount

Out-of-Pocket Amount (OOP) is the total amount you would pay in a single benefit year and is the sum of your deductible and copayments. Once the total of your deductible and copayments reaches this amount, your health plan pays 100 percent of the allowable fee on most covered services. The amount varies by plan option. Please see the Comparison of Benefits.

The Family OOP is twice that for an individual. Once the Family OOP is met, covered services are paid at 100 percent of the allowable charge for all covered family members.

There are some specified services for which this provision does not apply, including any amounts you pay for balances owed to nonparticipating providers.

Group Eligibility

Introduction

The Group Health Benefit Plan has policies governing enrollment of new members. In order to participate in the Group Plan, you must be a dues-paying member of the Association. Plan participants wishing to apply for membership in the Group Plan must go through an application process. At present, the directives for enrollment of new groups and new hires are below:

- All plans are guaranteed-issue plans for Association Participating Member groups.
 - Employees/dependents who apply for coverage within 31 days of completion of their waiting period (probationary period before new hires are eligible for coverage) are guaranteed coverage.
 - New hires and dependents may have a 12-month waiting period for preexisting conditions; however, creditable coverage applies.
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Participation Requirements

Employees who waive coverage and sign a waiver stating they have other coverage are not counted for participation purposes. If they lose eligibility for that coverage at a later date, they can enroll in the Group Plan by applying within 31 days of the loss of that eligibility. The table below describes participation requirements in regard to number of eligible employees. **Eligible employees covered elsewhere will affect participation requirements if only one employee decides to come onto the plan.**

Number of Eligible Employees	1–5	6–10	11–15	16–20	21 and over
Participation Requirement	All	All less 1	All less 2	All less 3	75%

Dependent Eligibility

Dependent children are eligible for coverage until their 25th birthday, regardless of whether or not they are attending college.

Participating Provider Networks

The Joint Venture Network: Big Sky Select Plan Only

Big Sky Select is a point-of-service (POS) plan with benefits that provide very attractive coverage with no deductible and lots of preventive health benefits when you go to your Personal Care Physician (PCP). **What makes this product so unique is that you can choose to go to any doctor you want and still have comprehensive coverage for your care.**

Levels of payment are determined by the participating status of the professional provider who provides your healthcare services:

	Services Provided By A	Benefit
Level A	Joint Venture Network Professional Provider, including Personal Care Physicians and Specialists	Member pays their office visit copayment.
Level B	BCBSMT Participating Professional Provider	Level B deductible and copayment apply.
Level C	Nonparticipating professional provider	Level C deductible and copayment apply.

BCBSMT Provider Network

Participating Professional Providers accept the BCBSMT allowable fee as their total reimbursement for covered services. Ninety (90) percent of all physicians in the state of Montana are Participating Physicians. BCBSMT pays these providers directly.

BCBSMT brings you the most extensive provider network available anywhere. In Montana, our network includes hospitals, physicians, outpatient surgery centers, skilled nursing facilities, home health agencies, hospice agencies, durable medical equipment supply houses, podiatrists, physician assistants, nurse practitioners, physical therapists, occupational therapists, speech therapists, chiropractors, certified nurse anesthetists, advanced practice registered nurses, psychologists, licensed professional counselors, optometrists, mental health social workers, and urgent care centers.

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Participating Provider Networks, Continued

Nonparticipating Providers Nonparticipating providers have not contracted with BCBSMT. You will receive payment for claims received from a nonparticipating provider. These providers are not under obligation to send claims in for you.

Nonparticipating providers are subject to a **differential**. This means that BCBSMT reduces the allowable fee by the following amounts **before** we calculate your benefits:

- Professional providers (e.g., doctors, physical therapists, nurse practitioners, radiologists) are subject to a 20 percent differential.
- Facility providers (e.g., hospitals, hospice, home health) are subject to a 20 percent differential.

Nonparticipating providers can bill you for this differential, **plus** any deductible and copayments, potentially making your out-of-pocket cost significantly higher.

HealthLink PPO

When you join the Montana HealthLink program, which includes preferred hospital providers, you are taking a strong, positive step toward affordable health care.

HealthLink is a group health benefit program developed by BCBSMT. The HealthLink benefit design uses a Preferred Provider Organization (PPO) concept for hospital-based inpatient and outpatient services.

HealthLink services are available statewide. You may elect to have services provided at any HealthLink facility in the state. When HealthLink hospitals are used, you are provided the highest level of services.

It is very important that you and your employees understand that services received outside the HealthLink PPO Network may result in significantly lower benefit payments.

For a current list of participating PPO hospitals, please visit the BCBSMT website at www.bluecrossmontana.com.

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Participating Provider Networks, Continued

Importance of Using the Network

Your health care provider may charge more than the allowable fee. If your health care provider is a nonparticipating provider, you are responsible for the balance of the nonparticipating provider's bill. Such additional charges are not covered by this group health plan.

The importance to you of such networks is that using providers in the network may reduce the overall cost of your health care. These providers accept the BCBSMT allowable fee as the full amount of payment for services—they may bill you for the deductible and copayment amounts, but not for charges in excess of the allowable fee for each service. These providers take care of all claims filing for you. Payment is made to the provider for claims from these providers.

Nonparticipating professional providers are allowed twenty percent (20%) less for their services. These providers may bill you the entire difference between their charge and the BCBSMT payment. Payment is made directly to you for claims from these providers.

Out-of-State and Worldwide Services

The BlueCard Program gives BCBSMT members access to Participating Provider arrangements between Blue Cross and Blue Shield Plans in other states and the providers in those states.

If a member chooses a Participating Provider in another state for health care services, the member may have discounts and hold-harmless provisions (no balance billing except your deductible and copayment) available. These providers will file claims for the member.

To find out whether a provider in another state is participating, call the toll-free BlueCard Access line at 1-800-888-BLUE. For a complete listing of Participating Providers worldwide, visit www.bcbs.com/healthtravel/finder.html.

Your nonparticipating provider, dental, and prescription drug claims may need to be submitted by you directly to BCBSMT.

Benefit Management

Introduction

Benefit management includes plan notification, prior authorization, and care management, which are designed to:

- Provide information regarding coverage before a member receives treatment, services, or supplies;
 - Inform the member about proposed procedures or alternate treatment plans;
 - Direct the member to the appropriate provider networks, including participating out-of-state networks;
 - Assist the member in determining out-of-pocket expenses and identify possible ways to reduce them;
 - Advise the member of the appropriate referrals required to ensure correct level of payment, if applicable;
 - Help the member avoid reductions in benefits that may occur if the services are not necessary or the setting is not appropriate.
 - When appropriate, assign a case manager to work with the member and his or her providers to design a treatment plan.
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Plan Notification

The member should notify BCBSMT of an inpatient admission, outpatient surgery, or other medical procedure or service as soon as the provider recommends or schedules services.

Note: It is not necessary to notify BCBSMT about standard x-ray and lab services or routine office visits.

Inpatient Admissions

The member should notify BCBSMT when an inpatient admission is scheduled ahead of time. Notification should occur as soon as the admission date is determined. If it is not possible to schedule the admission ahead of time, the member should notify BCBSMT within 24 hours of the admission or on the next working day.

Outpatient Surgeries and Other Medical Procedures and Services

If the member notifies BCBSMT prior to outpatient surgeries and other medical procedures, BCBSMT can advise the member which services are eligible for coverage and how choices in providers affect benefits.

Retrospective Review

If the member does not notify BCBSMT prior to admission or upon admission, a retrospective review may be performed after the claims have been submitted to determine whether or not the services, supplies, or treatment were medically necessary and the inpatient setting was appropriate. The member will be responsible for charges for any services that are determined not appropriate.

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Participating Provider Networks, Continued

Prior Authorization Prior authorization is recommended for some services to avoid unexpected expenses, benefit reductions, or claim denials. Prior authorization will help identify potential expenses to the member if the proposed services, supplies, medications, or ongoing treatment:

- Is not medically necessary;
 - Does not meet the criteria in the BCBSMT Medical Policy; or
 - Is not a benefit of the contract.
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Care Management The goal of care management is to help the member achieve a positive health outcome. If a member has an ongoing medical condition or a catastrophic illness, BCBSMT may be able to help manage the care needed. If appropriate, a care manager will be assigned to work with the patient and the provider to design a treatment plan. Care management includes member education, referral coordination, utilization review, and individual care planning.

Employee Assistance Program

Introduction The Employee Assistance Program (EAP) provides confidential assistance for personal problems that may be interfering with your life or work. EAP assistance is there when you need it most—when the problem is just beginning or when you have almost lost hope.

EAP Purpose The EAP is designed to provide short-term counseling to help regain control of your life. Often, all you need is a conversation with the counselor to gain perspective on a problem. All of the counselors are experienced and hold at least a master's degree in counseling or a related field.

Referrals At times, referral to an outside professional or community agency may be more appropriate. If a referral is made, the EAP counselor will work with you to ensure high quality, cost-effective help. You will be responsible for the cost associated with an outside referral. However, the EAP counselor will make every effort to use those professionals covered by your insurance plan. There is **never** any charge for the services provided by the EAP counselor.

Preexisting Condition Limitations

Length of Preexisting Condition Limitation

Benefits will be provided up to \$500 for covered medical expenses incurred as a result of preexisting conditions. This coverage is subject to the deductible and copayment provisions of your group health plan. Any covered medical expenses incurred beyond \$500 due to preexisting conditions will not be covered during the 12-month preexisting condition waiting period. **Note:** The \$500 benefit does not apply to any conditions that have been previously determined to be preexisting.

A preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date.

Time spent on the employer's waiting period to become eligible for the employer's group health plan runs concurrently with the preexisting condition exclusion time period.

Preexisting Condition Exclusions

The preexisting condition exclusion **does not** apply to:

- Newborn children of any family member; or
- Children placed for adoption as described in the definition of family member; or
- Pregnancy; or
- Any condition related to genetic information that has not been diagnosed.

If you had creditable coverage that was continuous within 63 days of your application for coverage under this health plan, credit toward satisfaction of the waiting period described above will be provided for the period of time during which you have been previously covered by creditable coverage.

Note: Days spent satisfying an employer's waiting period (probationary period) **do not** count toward the 63 days.

Creditable Coverage

Creditable coverage is coverage that an enrollee had for comprehensive medical benefits under any of the following plans, programs, and coverage:

- A group health plan
 - Health insurance coverage
 - Medicare
 - A medical care program of the Indian Health Service or of a tribal organization
 - A state health risk pool
 - A public health plan
 - TRICARE
 - Medicaid
 - Federal Employee Health Benefits Program (FEHBP)
 - A health benefit plan under Section 5(e) of the Peace Corps Act
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Preexisting Condition Limitations, Continued

Enrollment Date The enrollment date is the first day of coverage or, if there is an employer's waiting period (probationary period), the first day of the employer's waiting period.

Late Enrollee A late enrollee is an eligible employee or dependent who requests enrollment in a group health plan after the initial period of enrollment.

An eligible employee or dependent **is not** considered a late enrollee if:

- The individual requests enrollment within 31 days after termination of the creditable coverage and:
 - The individual was covered under creditable coverage at the time of the initial enrollment; or
 - The individual lost coverage under creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of the creditable coverage, the death of a spouse, divorce, or legal separation.
 - The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.
 - A court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.
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Special Enrollment Period A special enrollment period is allowed for eligible employees and/or dependents who are not currently enrolled and declined coverage because they had other coverage, and:

- Whose other coverage was as a COBRA-covered person and that coverage was exhausted;
- Who lost eligibility for the prior coverage;
- Who were covered on a group plan whose employer terminated contributions to that plan; and
- Who apply for coverage under the current employer's plan within 31 days of the termination of such coverage.

A special enrollment period also occurs when there is a change in family status. In the event of birth or adoption, the child and the employee's spouse may also enroll within 31 days of the event. In the event of a marriage, an employee previously eligible, but not enrolled, may enroll within 31 days of the marriage. The newly acquired spouse and/or children are also eligible to enroll within 31 days of the event.

Individuals enrolling during special enrollment periods **are not** late enrollees.

Benefit Comparison Summary 2009

All percentages are "of allowable fee" unless otherwise indicated.

COVERED SERVICES	CMM PPO			Big Sky Select	HEALTH FIRST PPO	CMM HSA PPO		
	Option 1	Option 2	Option 7	Option 3	Option 4	Option 5	Option 6	
LIFETIME MAXIMUM BENEFITS	\$5,000,000		\$250,000	\$5,000,000		\$5,000,000		
DEDUCTIBLE	Applies to all services unless specifically stated that the deductible is waived.							
	\$1,000 Individual \$2,000 Family	\$1,500 Individual \$3,000 Family	\$4,000 Individual \$8,000 Family Deductible is waived for the following services. <ul style="list-style-type: none"> • Diabetic Education • \$250 First dollar benefit • Home health care • Hospice • Mammograms • Newborn initial care • Well-child care 	Level A \$0 Level B \$750 Individual \$1,500 Family Level C \$1,500 Individual \$3,000 Family	\$500 Individual \$1,000 Family Deductible is waived for the following services. <ul style="list-style-type: none"> • Accident Benefit • Well-child care • Mammograms • \$100 preventive benefit • Diabetes Education • Participating professional providers • Newborn initial care • Immunization • Urgent Care 	\$3,000 Individual \$6,000 Family	\$4,800 Individual 9,600 Family Deductible is waived for the following services <ul style="list-style-type: none"> • Outpatient Diabetic Education • Mammogram benefit • Well-child care benefit • \$100 preventive benefit 	
COPAYMENT								
	50/50 Until OOP is met.			\$30 Office Visit 70/30 after deductible		50/50 until OOP is met.	100% after deductible is met.	
OUT-OF-POCKET AMOUNT (OOP) COPAYMENT LIMIT								
	\$3,000 Individual \$6,000 Family	\$4,500 Individual \$9,000 Family	\$8,000 Individual \$16,000 Family	\$2,000 Individual \$4,000 Family Not including Level B & C deductibles		\$2,000 Individual \$4,000 Family	\$3,000 Individual \$6,000 Family	\$4,800 Individual \$9,600 Family

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Benefit Comparison Summary

All percentages are “of allowable fee” unless otherwise indicated.

COVERED SERVICES	CMM PPO			Big Sky Select	HEALTH FIRST PPO	CMM HSA PPO	
	Option 1	Option 2	Options 7	Option 3	Option 4	Option 5	Option 6
PROFESSIONAL SERVICES	For the following services, there is a \$2,000 maximum per benefit period, combined, for outpatient professional and facility services: speech therapy, occupational therapy, physical therapy, and cardiac rehabilitation.					For the following services, there is a \$2,000 maximum per benefit period, combined for outpatient professional and facility services: speech therapy, occupational therapy, physical therapy and cardiac rehabilitation	
	Paid at 50% after deductible is met. Paid at 100% after OOP is met.			<p>Level A \$30 Copayment for office calls to Joint Venture Network Professional Providers</p> <p>Level B Deductible applies; then Services paid at 70% provided by a BCBSMT Participating Professional Provider.</p> <p>Level C Deductible applies; then services paid at 70% provided by a nonparticipating provider</p>	Paid at 50% after deductible is met. Paid at 100% after the OOP is met. Deductible is waived for participating professional providers.	Deductible applies. Paid at 100% after deductible is met.	
HOSPITAL SERVICES							
Inpatient	Room and board, special care units, ancillary charges, therapies, and transplant coverage. Transplants are paid as any other illness up to a \$500,000 lifetime maximum. This includes a maximum of \$10,000 for ambulance or air transport to the transplant site and \$25,000 maximum for organ procurement per transplant. Prescription drugs related to the covered transplant(s) are paid under the prescription drug benefit.						
	Maternity care and newborn care are paid as any other illness.						
Outpatient	Accidental injury, diagnostic x-ray and lab, surgery, emergency medical conditions, chemotherapy, respiratory therapy, radiation therapy.						
	Paid at 50% after deductible is met. Paid at 100% after OOP is met.			Inpatient and Outpatient benefits available on Level B or C only. Subject to deductible and coinsurance. Emergency Room \$100 copayment. No copayment on physician charges	Paid at 50% after deductible is met. Paid at 100% after OOP is met.	Paid at 100% after deductible is met	

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Benefit Comparison Summary

All percentages are “of allowable fee” unless otherwise indicated.

COVERED SERVICES	CMM PPO			Big Sky Select	HEALTH FIRST PPO	CMM HSA PPO	
	Option 1	Option 2	Options 7	Option 3	Option 4	Option 5	Option 6
CONVALESCENT HOME	Includes skilled nursing facilities, transitional care units, and extended care units/facilities.				Benefit Authorization is required		
	Deductible applies. Paid at 50% up to 60 days per benefit period. Paid at 100% after OOP is met.			Level B or C deductible applies. Paid at 70% up to 60 days per benefit period. Paid at 100% after OOP is met.	Deductible applies. Paid at 50% up to 60 days per benefit period. Paid at 100% after OOP is met.	Paid at 100% after deductible is met up to 60 days per benefit period.	
ACCIDENT-RELATED SERVICES							
	Deductible applies. Paid at 50% after deductible is met. Paid at 100% after OOP is met.			Emergency Room -\$100 copayment. Urgent Care -\$60 office visit copayment.	Paid at 100% up to \$300 per accident with no deductible for services provided within 90 days of the accident. Additional services related to the accident are paid under regular benefits.	Paid at 100% after deductible is met.	
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	Replacements and repair require prior authorization if the charges are over \$500. Repairs are paid up to the amount payable for replacement. The Out-of-Pocket amount (OOP) provision does not apply.				Purchases replacements and repairs require prior authorization if the charges are over \$500 Repairs are paid up to the amount payable for replacement.		
	Initial Purchase, Repair or Replacement Paid at 50%. Deductible applies			Deductible does not apply. Paid at 70%	Initial Purchase, Repair/ Replacement Paid at 50%. Deductible applies.	Paid at 100% after deductible is met.	
HOME HEALTH CARE	The Out-of-Pocket amount (OOP) provision does not apply. 180-visit maximum per benefit period.				120-visit maximum per benefit period	180 visit maximum per benefit period.	
	Deductible applies. Paid at 50% up to 180 visits per benefit period.			Deductible does not apply. Paid at 70%	Paid at 50% after deductible is met.	Paid at 100% after deductible is met.	
HOSPICE CARE	\$10,000 lifetime maximum.			\$10,000 lifetime maximum.			
	Paid at 100%. Deductible does not apply			Paid at 100%. Deductible does not apply.	Paid at 50% after deductible is met.	Paid at 100% after deductible is met.	

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Benefit Comparison Summary

All percentages are “of allowable fee” unless otherwise indicated.

COVERED SERVICES	CMM PPO			Big Sky Select	HEALTH FIRST PPO	CMM HSA PPO	
	Option 1	Option 2	Option 7	Option 3	Option 4	Option 5	Option 6
REHABILITATION THERAPY	Deductible applies. Paid at 50% up to \$100,000 per benefit period.			Inpatient paid at 70% coinsurance at Level B or C benefits. Outpatient paid on Level A copayment: Level B or C depending on provider.	Paid at 50% after deductible.	Paid at 100% after deductible is met.	
CHIROPRACTIC SERVICES	\$400 treatment/office visit maximum per benefit period. \$100 x-ray maximum.						
	Paid at 50% after deductible			Level A \$30 copayment applies. Level B or C deductible applies Paid at 70% coinsurance after deductible is met.	Paid at 50% after deductible.	Paid at 100% after deductible.	
MENTAL ILLNESS	Severe mental illness is paid the same as medical benefits. Partial hospitalization for mental illness is covered on a two-for-one basis – two days of partial hospitalization equals one day of inpatient care. There is a 21-day inpatient maximum per year.						
	Paid at 50% after deductible is met. Paid at 100% after OOP is met			Inpatient- Level B or C benefits apply. Deductible applies. Paid at 70% coinsurance after deductible is met. Outpatient – Level A copayment applies. Deductible applies on Level B or C. Paid at 70% coinsurance.	Paid at 50% after deductible. Paid at 100% after OOP is met.	Paid at 100% after deductible.	
CHEMICAL DEPENDENCY	Detoxification is paid under medical benefits. Maximum benefit of \$6,000 per year for inpatient and outpatient services until \$12,000 cumulative is paid for inpatient services; \$2,000 per year for inpatient and outpatient services thereafter.						
	Paid at 50% after deductible. Paid at 100% after OOP is met, up to maximums.			Inpatient – Level B or C benefits apply. Deductible applies. Paid at 70% coinsurance. Outpatient -Level A Copayment applies. Deductible applies on Level B or C. Paid at 70% coinsurance	Paid at 50% after deductible. Paid at 100% after OOP is met, up to maximums.	Deductible applies then paid at 100%	
WELL-CHILD CARE	Well-child exams and routine immunization through seven years of age.						
	Deductible is waived. Paid at 50%. Paid at 100% after OOP is met.			Level A copayment applies. Level B or C deductible waived. Paid at 70% coinsurance	Deductible waived. Paid at 50%	Deductible waived. Paid at 100%.	

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Benefit Comparison Summary

All percentages are “of allowable fee” unless otherwise indicated.

COVERED SERVICES	CMM PPO			Big Sky Select	HEALTH FIRST PPO	CMM HSA PPO	
	Option 1	Option 2	Option 7	Option 3	Option 4	Option 5	Option 6
MAMMOGRAMS	Paid at 100% of the actual charge or \$125, whichever is less. Additional charges are subject to deductible and coinsurance.			Deductible and copayment are waived. Paid at 100%	Paid at 100% of the actual charge or \$125, whichever is less. Additional charges are subject to the deductible and coinsurance.		
OUTPATIENT DIABETIC EDUCATION	Deductible does not apply coverage at 100% for the first \$250 per year.						
	Deductible applies to additional charges. Paid at 50%			Additional charges Level - A coverage at 100% Level B or C Deductible applies Paid at 70%	Deductible applies to additional charges. Paid at 50%	Deductible applies to additional charges. Paid at 100% after deductible is met.	
PRESCRIPTION DRUG PROGRAM	<p>\$400 deductible, separate from medical deductible then:</p> <p>Retail Pharmacy Purchase: Copayment for 34-day supply: \$8 Generic \$25 Formulary brand-name 25% Nonformulary brand name</p> <p>Mail Service Program: Copayment for 90-day supply: \$16 Generic \$50 Formulary brand-name 50% Nonformulary brand-name</p> <p>Mandatory generic replacement – member pays the difference between generic and brand-name drug if the generic is available but is not purchased, plus the applicable copayment</p>	<p>Member Purchases prescription at the local pharmacy and then submits to BCBSMT for processing. Deductible applies paid at 50% after deductible is met.</p> <p>50% coinsurance will not apply to Generic drugs.</p>	<p>\$100 deductible, separate from medical deductible then:</p> <p>Retail Pharmacy Purchase: Copayment for 34-day supply: \$8 Generic \$15 Formulary brand-name \$30 Nonformulary brand-name</p> <p>Mail Service Program: Copayment for 90-day supply: \$16 Generic \$30 Formulary brand-name \$60 Nonformulary brand-name</p> <p>Mandatory generic replacement- member pays the difference between generic and brand-name drug if the generic is available but is not purchased, plus the applicable copayment</p>	<p>Member purchases prescription at the local pharmacy, and then submits to BCBSMT for processing. Deductible applies. Paid at 100% after deductible is met.</p>			

Services and Supplies Not Covered

Introduction

The following is only a partial list of items not covered. Read your member certificate or group contract carefully to determine which expenses are covered.

- Workers' Compensation cases.
- Benefits payable under the medical expense provisions of an automobile insurance policy.
- Services required as a result of war, insurrection, armed invasion, or terrorism.
- Dental care except as specifically included.
- Radial keratotomy (refractive keratoplasty) or other surgical procedures to correct myopia/astigmatism.
- Services and supplies related to in vitro fertilization.
- Services related to sexual dysfunction.
- Reverse sterilization.
- Experimental surgery or medical care including experimental drugs, diets, and those services that are not accepted medical practice.
- Premarital, pre-employment, or routine physical exams, except as specifically provided for in these plans.
- Services and supplies beginning before your effective date or after your coverage is no longer in effect.
- Services and supplies not necessary to treat active illness or injury, except as specifically stated as covered.
- Services provided by federal or state law, including Medicare A and B and the Veterans Administration, except those provided by the VA that are not service-related.
- Nonsurgical treatment of temporomandibular joint syndrome (TMJ). Surgical treatment of TMJ or malocclusion of the jaw requires prior authorization.
- Hearing aids and related services.
- Cosmetic and obesity surgery, medicines, supplies, and treatment, except cosmetic surgery as required due to an accident or a birth defect, which is covered.
- Chemical dependency and mental illness, except as specifically included.
- Custodial care or rest cures.
- Travel, except necessary ground/air ambulance transportation.
- Services and supplies for which the patient has no legal obligation to pay.
- Services or supplies not listed as a benefit of the contract.
- Chiropractic maintenance therapy.

Note: This brochure is only an outline of benefits, and your group contract will prevail.



MNA SUBGROUP NO. _____

**MONTANA NONPROFIT ASSOCIATION
GROUP HEALTH BENEFITS PLAN EMPLOYER ELECTION FORM**

Group Name _____			Group Contact Name _____		
Physical Address _____			Mailing Address _____		
City _____ State _____ Zip Code _____			City _____ State _____ Zip Code _____		
			E-Mail Address _____		
Telephone () _____			FAX () _____		

1. Employer Tax Identification Number. If you have no TIN, Social Security Number: _____
2. For the current calendar year (January 1 – Present), state the total number of employees: Coverage _____
 Have you had 20 or more employees during 20 or more work weeks? Yes No
 Do you expect to have 20 or more employees during at least 50% of your typical business days? Yes No
3. For the previous calendar year (January 1–December 31), state the total number of employees: _____
 Did you have 20 or more employees during 20 or more work weeks? Yes No
 Did you have 20 or more employees during at least 50% of your typical business days? Yes No
4. Current number of employees _____ Number of eligible employees _____ Number of enrolled employees _____
 If your group is COBRA eligible, COBRA will be administered by HealthServe.
5. If COBRA eligible, number of COBRA participants enrolling _____
6. Group waiting period (probationary period): *(Must not exceed 330 days)* _____ Days
7. Number of work hours per week required to be eligible for benefits: _____ Hours
8. Employer contribution to premium (% or \$):
 _____ % or \$ _____ Employee
 _____ % or \$ _____ Dependent

Please review definitions on reverse.

BENEFIT OPTIONS

- Option 1 CMM PPO 50/50 - \$1,000 Deductible; RX \$400 \$8/25/25%
- Option 2 CMM PPO 50/50 - \$1,500 Deductible; RX \$400 \$8/25/25%
- Option 3 Big Sky Select 70/30 - \$30 Copay; RX \$100 \$8/15/30**
- Option 4 Health First PPO 50/50 - \$500 Deductible; RX \$100 \$8/15/30**
- Option 5 CMM HSA PPO 100/0 - \$3,000 Deductible**
- Option 6 CMM HSA PPO 100/0 - \$4,800 Deductible
- Option 7 CMM PPO 50/50 - \$4,000 Deductible;
 \$250,000 Lifetime Maximum, \$100,000 Annual Maximum

Effective Date:

_____ / _____ / _____

Rate Level: _____

I certify that all information provided by me to complete this application is true.

Printed Name of Group Leader _____	Title _____	Representative Name _____
Signature _____	Date _____	Representative No. _____

DEFINITIONS

The total number of employees includes the following:

1. Active employees who are working full-time, part-time, or seasonally; or
2. Employees who **are not** currently working, but who are either:
 - On disability, but **not** for more than six months; or
 - Laid off, on sick leave, or a seasonal worker; and who **have not** been terminated, **are not** receiving disability for more than six months, **are not** receiving Social Security benefits, and **are not** covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272) requires employers of 20 or more employees to continue health care coverage for terminated employees and for the widows, ex-spouses, and dependents of employees, effective for plan years beginning after June 30, 1986.

The term **plan sponsor** means:

The employer in the case of an employee benefit plan established or maintained by a single employer.

The employee organization in the case of a plan established or maintained by an employee organization or in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

Submit **New Group** paperwork to: Marketing Department, Blue Cross and Blue Shield of Montana, PO Box 4309, Helena, MT 59604

Submit Renewal paperwork to: HealthServe, 1 N Last Chance Gulch Ste 4, Helena, MT 59601

**For more information contact
Mountain West Benefits Solutions
1-877-343-1060
or in Helena call 443-1059**

**Blue Cross and Blue Shield Of Montana
560 North Park Avenue
P.O. Box 4309
Helena, MT 59604-4309**



An Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans.