Clear Choice HDHP
HSA Qualified 2,500
Summary of Benefits

CLEAR CHOICE HEALTH PLANS, INC.

2650 NE Courtney Dr., Bend, OR 97701
40 Four Mile Dr., Ste. 8, Kalispell, MT 59901

Amendment to: Clear Choice Individual Health Plan Contract

Section I of the Clear Choice Individual Health Plan Contract (2008 MT Individual 001) is amended by adding the following Plan description and benefit limits:

	IN-NETWORK	OUT-OF-NETWORK	DESCRIPTION
LIFETIME MAXIMUM BENEFIT:	**$2 million**		In-Network and Out-of-Network benefits accumulate together towards the Lifetime Maximum Benefit.
CALENDAR YEAR DEDUCTIBLE Per Covered Person:	**$2,500**		The Deductible is the amount of covered expenses that are paid by the Covered Person before benefits are payable under the Plan.
CALENDAR YEAR DEDUCTIBLE Per Family:	**$5,000**		The Deductible applies separately to each covered person, but no family will be required to satisfy more than the total family Deductible as shown.
OUT-OF-POCKET MAXIMUM (OOPM)* Per Covered Person:	**$2,500**	**$7,500**	Annual Out-of-Pocket Maximums include Deductibles.
OUT-OF-POCKET MAXIMUM (OOPM)* Per Family:	**$5,000**	**$15,000**	

***The following services provided pursuant to the Agreement and this Amendment do not accrue toward the Out-of-Pocket Maximum:

- Charges for services provided which are not covered under the Individual's Plan.

BENEFIT DESCRIPTION	COVERED PERSON RESPONSIBILITY FOR COVERED SERVICES RECEIVED FROM AN IN-NETWORK (PARTICIPATING) PROVIDER	COVERED PERSON RESPONSIBILITY FOR COVERED SERVICES RECEIVED FROM AN OUT-OF-NETWORK (NON-PARTICIPATING) PROVIDER
PREVENTIVE SERVICES		
Routine Physical Exams[1]	**0% Coinsurance***,[2]	**25% Coinsurance**
Routine Immunizations/Vaccinations	**0% Coinsurance***,[2]	**25% Coinsurance**
Well-Child Care[1]	**0% Coinsurance***	**25% Coinsurance**
Routine Women's Health Exam[1] (Pap Test, Breast Exam, Pelvic Exam)	**0% Coinsurance***,[2]	**25% Coinsurance**
Routine Mammography[1]	**0% Coinsurance***	**25% Coinsurance**
Routine Colon Cancer Screening[1]	**0% Coinsurance***	**25% Coinsurance**
PHYSICIAN SERVICES		
Office Visits	**0% Coinsurance**	**25% Coinsurance**
Outpatient Lab & X-Ray	**0% Coinsurance**	**25% Coinsurance**
Other Diagnostics (MRI/CT/Nuclear Medicine)	**0% Coinsurance**	**25% Coinsurance**
Allergy Shots & Therapeutic Injections	**0% Coinsurance**	**25% Coinsurance**
Other Office Procedures	**0% Coinsurance**	**25% Coinsurance**
BEHAVIORAL HEALTH SERVICES[1]		
Inpatient/Outpatient Mental Health	**0% Coinsurance**	**25% Coinsurance**
Inpatient/Outpatient Chemical Dependency	**0% Coinsurance**	**25% Coinsurance**
HOSPITAL & OUTPATIENT SERVICES		
Inpatient, Outpatient & Surgery Center	**0% Coinsurance**	**25% Coinsurance**
Physician Services	**0% Coinsurance**	**25% Coinsurance**
Inpatient Lab & X-Ray Services	**0% Coinsurance**	**25% Coinsurance**
Inpatient Rehabilitation Therapy[1]	**0% Coinsurance**	**25% Coinsurance**
MATERNITY SERVICES		
Prenatal, Delivery, & Postnatal Physician Services	**0% Coinsurance**	**25% Coinsurance**
Hospital Services	**0% Coinsurance**	**25% Coinsurance**

BENEFIT DESCRIPTION	COVERED PERSON RESPONSIBILITY FOR COVERED SERVICES RECEIVED FROM AN IN-NETWORK (PARTICIPATING) PROVIDER	COVERED PERSON RESPONSIBILITY FOR COVERED SERVICES RECEIVED FROM AN OUT-OF-NETWORK (NON-PARTICIPATING) PROVIDER
EMERGENCY SERVICES		
Urgent Care Facility	**0% Coinsurance**	**25% Coinsurance**
Emergency Room (Includes ER Physician & Facility)	**0% Coinsurance**	**25% Coinsurance**
Lab & X-Ray	**0% Coinsurance**	**25% Coinsurance**
Ambulance Services[1]	**0% Coinsurance**	**25% Coinsurance**
OTHER FACILITIES & SERVICES[1]		
Outpatient Rehabilitation Services	**0% Coinsurance**	**25% Coinsurance**
Durable Medical Equipment, Prosthetics & Supplies	**0% Coinsurance**	**25% Coinsurance**
Chiropractic Care	**0% Coinsurance**	**25% Coinsurance**
Skilled Nursing Facility / Convalescent Home	**0% Coinsurance**	**25% Coinsurance**
Diabetic Education Benefit	**0% Coinsurance**	**0% Coinsurance**
Home Health Care	**0% Coinsurance**	**25% Coinsurance**
Hospice	**0% Coinsurance**	**25% Coinsurance**
Transplants	**0% Coinsurance**	**25% Coinsurance**
Routine Refractive Eye Exam	**0% Coinsurance**	**25% Coinsurance**
PRESCRIPTION SERVICES[3]		
Calendar Year Deductible	**Subject to Medical**	**Not Covered**
Formulary Generic – 1 Month Supply	**0% Coinsurance**	
Formulary Brand – 1 Month Supply		
Non-Formulary – 1 Month Supply		
Self-Injectable – 1 Month Supply		
Mail Order – 3 Month Supply	**3 Month Supply for 2x Copayment/Coinsurance**	

*** = Deductible Waived.**
1 = Subject to Plan Limits.
2 = Pays 100% of Allowable Fee up to $150 per Calendar Year, not subject to Deductible.
3 = Subject to Prescription Drug Plan Limits.

PLAN LIMITS:

The following benefits are limited by the Plan and are subject to all coverage guidelines in the Agreement and Plan Deductible, Copayments, and Coinsurance as stated in the benefit grid above.

Ambulance: Benefits are limited to a Calendar Year maximum benefit of:

- **Air Transportation:** $3,500 maximum per Calendar Year
- **Ground Transportation:** unlimited

Biofeedback Therapy: Benefits are limited to a lifetime maximum of 10 visits per Covered Person.

Treatment for Chemical Dependency: Benefits for the treatment of chemical dependency are limited to a Calendar Year maximum benefit of $3,000 for inpatient services. Benefits are limited to a $6,000 lifetime maximum benefit for inpatient services. Outpatient services are limited to a Calendar Year maximum benefit of $1,000.
Note: Treatment for medical detoxification will be covered under regular medical benefits.

Chiropractic Services: Benefits for chiropractic care are limited to a Calendar Year maximum of $500. This benefit includes x-ray services provided by a Chiropractor.

Colon Cancer Screening: Routine preventive Colon Cancer Screening benefits are limited to the following exam schedule:

- **< Age 50:** high risk only
- **> Age 50:** 1 fecal occult blood test every year;
  1 flexible sigmoidoscopy every 5 years; and
  1 colonoscopy every 10 years OR 1 double contrast barium enema every 5 years

Diabetes Self-Management Training and Education: Benefits are limited to a Calendar Year maximum of $250 for Medically Necessary and prescribed outpatient self-management training and education for the treatment of diabetes. No benefits will be paid for these health care services once the $250 benefit has been paid.

Durable Medical Equipment: Benefits are limited to a Calendar Year maximum benefit of $5,000; Supplies: Unlimited.

Home Health Visits: Benefits are limited to a Calendar Year maximum of $12,000.

Hospice: Benefits are limited to a lifetime maximum of $10,000.

Treatment for Mental Illness: Inpatient services for the treatment of mental illness are limited to a Calendar Year maximum of 21 days, or 42 partial inpatient days. Outpatient services are limited to a Calendar Year maximum of $2,000.
Note: Severe Mental Illness is covered under regular medical benefits.

Physical, Occupational, Speech Therapy, Cardiac, Pulmonary: Benefits are limited to a Calendar Year maximum of:

- **Outpatient:** 20 visits per Calendar Year
- **Inpatient:** 30 days per Calendar Year

Post Cataract Surgery: Eyeglasses or Contact Lenses are covered after cataract surgery and are paid at 100% up to a maximum benefit of $250 per unit after each surgery.

Prescription Drugs and Injectable Drugs: Prescription and Injectable Drugs are limited to the following in-network benefit:

- **Generic Drugs:** no annual limit
- **Brand, Non-Formulary & Self Injectable:** $3,000 combined Calendar Year Maximum

Routine Mammography: Benefits for routine annual mammography are limited to the following exam schedule:

- **Women age 35-39:** one baseline mammogram
- **Women age 40-49:** one mammogram every two years
- **Women age 50+:** one mammogram every year

Mammograms may be obtained more frequently if recommended by the Covered Person's physician.

Benefits for routine mammography will be paid at 100%, and are not subject to deductible.

Routine Refractive Eye Exam: Benefits are limited to a Calendar Year maximum of $75.

Routine Women's Health Exam: Women's pelvic and Pap smear examinations, including breast exams, are covered once every Calendar Year.

Skilled Nursing Facility/Convalescent Home: Benefits are limited to a Calendar Year maximum benefit of 60 days.

Transplant Services, In-Network: Benefits are limited to an in-network lifetime maximum benefit of $250,000. Transplant donor services are limited to $8,000 per covered transplant.

Transplant Services, Out-of-Network: Benefits are limited to an out-of-network lifetime maximum benefit of $100,000 or 50%; whichever is less. Transplant donor services are limited to $8,000 per covered transplant.

Well-Child Care and Routine Physical Health Examinations: Benefits are limited to the following exam schedule:

- **Birth through 7 years of age:** Well-child care
- **Children (Ages 8-18):** 1 exam every 2 years
- **Adults (Ages 19-29):** 1 exam every 5 years
- **Adults (Ages 30-39):** 1 exam every 3 years
- **Adults (Ages 40-49):** 1 exam every 2 years
- **Adults (Ages 50+):** 1 exam every year