Outline of Coverage for 2008
The following information is a summary of benefits provided for the Essential Care Plan. Benefits and general provisions described herein are subject to terms of the actual Contract.

### Lifetime Maximum Benefit
$1,000,000

### Benefit Period
Calendar year (January 1 through December 31)

### Deductible
- **Individual**: $200
- **Family**: $400

### Coinsurance
- **BCBSMT Pays**: 70%
- **Member Pays**: 30%

### Out of Pocket Amount
The total amount you would pay in a single benefit period. BCBSMT pays 100% of the allowable fee on most services after the deductible and co-insurance have been satisfied. Any amount you pay for balances owed to Non-Participating providers does not apply to the Out of Pocket Amount.
- **Individual**: $2,000
- **Family**: $4,000

### Outpatient Surgery Benefit
$200 deductible per surgery (does not apply to the regular deductible or the Out of Pocket Amount)

Waiting Period for Pre-existing Conditions is 12 months. If you had Creditable Coverage that was continuous within 63 days of your Certificate of Creditable Coverage being issued, that coverage will be credited toward the waiting period.

Blue Card Out-of-State and World-Wide Health Care Services
The BlueCard Program enables BCBSMT members who are traveling or living in another Blue Plan’s service area to receive all the same benefits of their BCBSMT Plan and access to BlueCard providers and savings.

If you choose a Participating Provider in another state for health care services, these providers will file claims for you. There may be no balance billing except for your deductible.

### Participating Provider
**Physicians and Other Medical Professionals**
Participating Providers (physicians and other medical professionals, such as physical therapists, nurse practitioners, etc.) have not contracted with BCBSMT, and your out of pocket expenses can be significantly higher.

Non-Participating providers are subject to a 20% differential which means BCBSMT reduces its allowable fee by 20% before calculating your benefits. You may be balance billed by the Non-Participating provider for the difference between the BCBSMT payment and the total charge including any deductible and coinsurance amounts.

To find BlueCard Participating Providers, call 1-800-810-BLUE (2583) or visit our website at www.bcbs.com/healthtravel/.
**Benefit Highlights** *(for more detailed information, refer to your Contract)*

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Provider Services</td>
<td>Outpatient surgeon (subject to the Outpatient Surgery Benefit), anesthesia, (limited maternity services, as outlined in your contract).</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Room and board, special care units, ancillary charges and transplant coverage. Emergency Room services are only a benefit if you are admitted inpatient from the Emergency Room.</td>
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<tr>
<td>Outpatient Hospital</td>
<td>Chemotherapy, radiation therapy, dialysis.</td>
</tr>
<tr>
<td>Accident</td>
<td>$200 maximum per accident. Accident benefits are payable only for services received within 72 hours of the accident.</td>
</tr>
<tr>
<td>Individual Therapies</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Rehabilitation Therapy</td>
<td>$100,000 lifetime maximum, per member combined for inpatient and outpatient rehabilitation therapy services.</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Mental Illness (Outpatient &amp; Inpatient)</td>
<td><em>Note: Severe Mental Illness is processed under regular medical benefits.</em> Not covered.</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Well-Child Care*</td>
<td>Well-child exams, lab tests and immunizations through seven years of age.</td>
</tr>
<tr>
<td>Mammograms</td>
<td>Paid at 100% the actual charge or $70, whichever is less. Deductible and co-insurance apply to any balance after the first $70 is paid.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>
| **Outpatient Surgery Benefit** | Surgeries provided in a hospital or a freestanding surgicenter are covered under this benefit. Surgeries in a doctors office are not covered.  
- $200 deductible PER SURGERY.  
- BCBSMT pays 70% of the allowable fee after the deductible is met.  
- $5,000 Maximum Member Liability per benefit period for this Benefit.  
- After the $5,000 Maximum Member Liability is reached, the coinsurance for this benefit will no longer apply. Deductible continues to apply.  
**Covered Services:** Surgery, Anesthesia, Facility Charges, Diagnostic Lab & X-ray services related to the surgery (these services are covered if performed within seven days of the surgery). |

* Deductible does not apply.

Benefits are not available for the following services under the Essential Care Plan. Please see your Contract for a comprehensive listing of excluded conditions, services, treatments, and procedures.

- Mental Illness
- Home Health
- Prescription Drugs
- Convalescent Home Care
- Chiropractic
- Outpatient Physical, Speech, and Occupational Therapies
- Chemical Dependency

*To learn more about the Essential Care Plan, call Blue Cross and Blue Shield of Montana at 1-800-447-7828, Extension 8965, or your local BCBSMT agent, or visit our website at www.bcbsmt.com.*

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