

## Outline of Coverage | 2010

**Choose Your Benefits:** Create your unique health insurance plan by choosing a Deductible, Coinsurance, and Out-of-Pocket Amount from the options below.

	Deductible		Coinsurance	Out-of-Pocket Amount*	
	Individual	Family		Individual	Family
<input type="checkbox"/>	\$3,000	\$6,000	100/0	\$3,000	\$6,000
<input type="checkbox"/>	\$3,000	\$6,000	50/50	\$5,000	\$10,000
<input type="checkbox"/>	\$3,000	\$6,000	70/30	\$4,000	\$8,000
<input type="checkbox"/>	\$5,950	\$11,900	100/0	\$5,950	\$11,900

<b>Benefit Period</b>	Calendar Year (January 1 - December 31)
<b>Lifetime Maximum Benefit</b>	\$3,000,000
<b>Deductible</b>	Benefits begin for a single family member once the individual deductible for that member has been met, or once the family deductible is met for two or more covered persons—whichever comes first.
<b>Preventive Health Benefit</b>	Pays 100% of the allowable fee up to \$250 per benefit period for Preventive Health Care.
<b>Network</b>	Healthlink PPO ( <i>Hospitals and Surgery Centers</i> )   Traditional ( <i>Physicians and Professional Providers</i> )
<b>Nonparticipating Provider Differential/Non-PPO Network Provider Benefit Reduction**</b>	25% Sanction for Non-PPO Hospital or Surgery Center 10% Differential for Nonparticipating Providers
<b>Exclusion Period for Preexisting Conditions</b>	12 months. <i>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 exclusion period.</i>

## BCBSMT Provider Networks

**Healthlink Preferred Provider Organization (PPO) -** An innovative health care partnership developed by BCBSMT and our Preferred Hospital Providers to offer health care services to qualified members at lower premiums. This network is composed of hospitals and surgery centers across the state that accept lower payments for each hospital or surgery center service or inpatient stay. Currently, all hospitals in Montana participate in this network.

**Traditional Network Participating Providers -** This is the most extensive provider network available in Montana, composed of professional providers (e.g. physicians, physical therapists, nurse practitioners) that have contracted with BCBSMT to provide services to our members at discounted rates. Currently, approximately 95% of all physicians in Montana participate in this network.

Participating Providers accept the BCBSMT allowable fee as payment in full for covered services. These providers will submit your claim for you, and BCBSMT will pay the participating provider directly. There is no billing to you over your deductible and coinsurance.

**Nonparticipating Provider -** Nonparticipating Providers have not contracted with BCBSMT to provide services at negotiated rates, and your out of pocket expenses can be significantly higher. You will receive payment for claims received from a nonparticipating provider. However, these providers are subject to a differential and are under no obligation to submit claims for you.

**Finding Participating Providers -** To locate Participating Providers and HealthLink PPO hospitals and surgery centers in Montana check our on-line provider directory at [www.bcbsmt.com](http://www.bcbsmt.com), or contact Customer Service at 1-800-447-7828. Be sure to have your subscriber identification number available when you call.

**World-Wide Networks at Your Fingertips -** With BlueCard, you have access to Participating Providers across the country and around the world. No matter where you are, you'll receive the same great benefits you get when you're at home. To find BlueCard Participating Providers, visit the BlueCross and BlueShield Association website at [www.bcbs.com/healthtravel/](http://www.bcbs.com/healthtravel/) or call 1-800-810-BLUE (2583).

**Lifetime Maximum Benefit:** The total amount per Member BCBSMT will pay for specific benefits or all benefits while the Member is continuously covered by the same employer, organization, or trust.

**Deductible:** The dollar amount each Member must pay for covered medical expenses incurred during the benefit period before BCBSMT will make payment for any covered medical expense to which the deductible applies.

**\*Out-of-Pocket Amount:** The total amount you would pay in a single benefit period. Once the total of your deductible and coinsurance reaches this amount, the Plan pays 100% of the allowable fee on most covered services. Any amount you pay for balances owed to nonparticipating providers does not apply to the Out-of-Pocket individual/family amount.

**Coinsurance:** The percentage of the allowable fee payable by the Member for covered medical expenses.

**Copayment:** The specific dollar amount payable by the Member for covered medical expenses.

**\*\*Non-PPO Network Provider Benefit Reduction:** If services or supplies are obtained from a Non-HealthLink hospital or surgery center, payment will be reduced by 25% from that which would be paid to a HealthLink hospital or surgery center. Any payment reduction is the Member's responsibility.

**\*\*Nonparticipating Provider Differential:** The allowable fee for Nonparticipating Providers is reduced by 10% before deductible and coinsurance are applied. The difference between the allowable fee and the total charge is the Member's responsibility.

**Preexisting Condition:** A condition for which medical advice, diagnosis, care or treatment was recommended or received within the 36-month period ending on the member's enrollment date.



## Benefit Highlights [Deductible and coinsurance apply to all services listed below, unless otherwise noted]

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.

Professional Provider Services	Home and office calls, surgery, anesthesia, diagnostic lab and x-ray, and other services provided by a professional provider.
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, surgicenter, oxygen and equipment for use in the home, blood transfusion services, ambulance, medical supplies for use outside hospital, orthopedic devices.
Chiropractic Services	Not Covered.
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 combined for inpatient and outpatient rehabilitation therapy services.
Durable Medical Equipment and Prostheses	\$7,500 maximum per member per benefit period. Initial purchase, replacements and repair. Prior authorization is recommended if charges are over \$500.
Mental Illness	<b>Note: Severe Mental Illness is processed under regular medical benefits.</b>
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 24-month period.  \$8,000 lifetime maximum benefit.
Well-Child Care	Well-child exams, and immunizations through seven years of age. Lab tests as recommended for routine well-child care from birth through seven years of age. Deductible does not apply.
Mammograms	Paid at the actual charge or \$70, whichever is less, for each covered mammogram. Deductible and coinsurance apply after the first \$70 is paid.
Diabetic Education Benefit	Up to \$250 per benefit period for outpatient services.
Prescription Drugs	Processed under regular medical benefits. \$2,500 maximum per member per benefit period.
Ambulance	Processed under regular medical benefits. \$10,000 maximum per benefit period.
Preventive Health Care	Routine* services, available only for Members age 8 and older, are: Pap tests, related lab charges and related office visit; Proctoscopies, sigmoidoscopies, colonoscopies, or hemocults and related office calls; Immunoassay for tumor antigen or prostate specific antigen (PSA) and related office call; Physical examinations and related tests as recommended for routine physical exams; Routine diagnostic x-ray and laboratory services, including but not limited to chemistry screens, cholesterol and other blood fat tests and thyroid (T4) test; Immunizations and vaccinations. Deductible does not apply.  <i>*Routine - Examinations or services provided when there is no objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any injury or illness.</i>

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