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COMPREHENSIVE MAJOR MEDICAL HSA HEALTHLINK

To learn more call Blue Cross and Blue Shield of Montana at 800.447.7828 or your local agent.
www.bcbsmt.com

Outline of Coverage | 2011

Benefit Period	Calendar Year (January 1 - December 31)
Deductible	Individual $2,700 | Family Aggregate $5,400
Out-of-Pocket Amount	Individual $2,700 | Family Aggregate $5,400
Coinsurance	0%
Network	Healthlink PPO *(Hospitals and Surgery Centers)* | Traditional *(Physicians and Professional Providers)*
Nonparticipating Provider Differential	10%
Non-PPO Network Provider Benefit Reduction	25%
Exclusion Period for Preexisting Conditions (Does not apply to Members under 19 years of age.)	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 exclusion period.*
Deductible Waived For:	Diabetic Education Benefit, Well-Child Care, Preventive Health Care, Routine Mammograms

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, 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/ or call 1-800-810-BLUE (2583).

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 coinsurance reaches this amount, the Plan pays 100% of the allowable fee on most covered services. Any amount you pay for balances owed to non-participating 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.

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 6-month period ending on the Member's enrollment date.

COMPREHENSIVE MAJOR MEDICAL HEALTHLINK

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 and Durable Medical Equipment over $500. Refer to your Member Guide.

Professional Provider Services	Covered services include home and office calls, x-ray, lab, and other services provided by a Participating Professional Provider.
Preventive Health Care	Services include, but are not limited to: 1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's current recommendations; and 2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention; and 3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women; and 4. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to November 2009. Examples of Preventive Health Care services include, but are not limited to, physical examinations, colonoscopies, immunizations and vaccinations. Paid at 100% of the allowable fee.
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, and other services.
Transplants	Processed under regular medical benefits.
Convalescent Home	Skilled nursing facility, transitional care units, and extended care facilities. Up to 60 days per benefit period.
Chiropractic Services	$600 maximum per benefit period. Does not include x-ray maximum. X-ray maximum: $100 per benefit period.
Home Health Care	Up to 180 visits per benefit period.
Hospice	Inpatient and outpatient care, home care, skilled nursing, counseling and other support services.
Individual Therapies	Physical, occupational, speech, and cardiac rehabilitation therapies for outpatient professional and facility charges.
Rehabilitation Therapy	Inpatient and outpatient rehabilitation therapy services.
Supplemental Accident	Processed under regular medical benefits.
Durable Medical Equipment and Prostheses	Initial purchase, replacements and repair. Prior authorization is recommended if charges are over $500.
Mental Illness	Mental Illness, including Severe Mental Illness, is processed under regular medical benefits.
Chemical Dependency	Processed under regular medical benefits.
Well-Child Care	Exams, lab tests, and routine immunizations. Paid at 100% of the allowable fee.
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 to ABA therapy: $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. (ABA therapy is only available to members 0-18 years of age.)
Mammograms	Paid at 100% of the allowable fee for routine mammograms. Deductible applies to mammograms with a medical diagnosis.
Diabetic Education Benefit	Up to $250 per benefit period for outpatient services. Deductible and coinsurance apply after the first $250 is paid.
Prescription Drugs	Processed under regular medical benefits

[This information is only a summary of benefits. For more detailed information, refer to your Member Guide. Benefits and general provisions described herein are subject to the terms of the Member Guide or Group Contract.]

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