

INSURE MONTANA

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www.bcbsmt.com

STANDARD PLAN

Outline of Coverage | 2011

Benefit Period	Calendar Year (January 1 - December 31)
Deductible	Individual \$1,500 Family Aggregate \$3,000
Out-of-Pocket Amount	Individual \$3,500 Family Aggregate \$7,000
Coinsurance	40%
Network	Traditional
Nonparticipating Provider Differential	20%
Exclusion Period for Preexisting Conditions (Does not apply to members under 19 years of age.)	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>
Deductible Waived For: <i>Note: Prescription drugs have their own deductible.</i>	Participating Professional Provider Services, Diabetic Education Benefit, Well-Child Care, Newborn Initial Care, Home Health, Hospice, Mammograms, and Preventive Health Care.
Office Visits	First two professional physician office visits per member per benefit period paid at 100%. Services must be provided by a Participating Professional Provider.

BCBSMT Provider Networks

Traditional Network Participating Providers - This is the most extensive provider network available in Montana, composed of facilities (e.g., hospitals, outpatient surgery centers, skilled nursing facilities) and 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 and 100% of hospitals 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 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 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 non-participating providers, rehabilitation therapy benefits, durable medical equipment and prosthetics, home health, and prescriptions, 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.

Nonparticipating Provider Differential: The allowable fee for Nonparticipating Providers is reduced by 20% 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.

**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	Deductible waived for Participating Professional Providers. Covered services include home and office calls, x-ray, lab, and other services provided by a Participating Professional Provider.
Preventive Health Care	<p>Services include, but are not limited to:</p> <ol style="list-style-type: none"> 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. <p>Examples of Preventive Health Care services include, but are not limited to, physical examinations, colonoscopies, immunizations and vaccinations. Paid at 100% of allowable fee.</p>
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, paid at 50%, deductible waived.
Hospice	Paid at 100% of the allowable fee.
Individual Therapies	Physical, occupational, speech, and cardiac rehabilitation therapies for outpatient professional and facility charges. Deductible waived for Participating Professional Provider services.
Rehabilitation Therapy	Inpatient and outpatient rehabilitation therapy services. Deductible waived for Participating Professional Provider 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	<p>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.</p> <p>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.)</p>
Mammograms	Paid at 100% of the allowable fee.
Diabetic Education Benefit	Up to \$250 per benefit period for outpatient services. Deductible and coinsurance apply after the first \$250 is paid.
Prescription Drugs	<p>Retail purchase, 34-day supply: \$10 generic; \$30 formulary; \$75 brand name</p> <p>Mail-order purchase, 90-day supply: \$20 generic; \$60 formulary; \$150 brand name</p>
	<i>\$100 deductible per family Member, then:</i>

[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.]