BLUE PREFERRED GOLD PPO 005

BlueCross BlueShield of Montana

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 | 2014

This plan does not have an Annual or Lifetime Plan Maximum

Benefit Period	January 1 - December 31
Deductible Copayments and coinsurance do not accumulate to deductible.	In-Network: Individual $2,000 Family $4,000 Out-of-Network: Individual $4,000 Family $8,000
Out-of-Pocket Amount	In-Network: Individual $3,250 Family $6,500 Out-of-Network: Individual $6,500 Family $13,000
Coinsurance	In-Network: 20% Out-of-Network: 40%
Copayment *Copayments are in addition to deductible and coinsurance. Once the out-of-pocket amount is satisfied, deductible, coinsurance and copayments do not apply.	Primary Care Physician (PCP): In-Network $30 Out-of-Network: No copayment, deductible and coinsurance apply Specialist: In-Network $50 Out-of-Network: No copayment, deductible and coinsurance apply Emergency Room: In-Network $400* Out-of-Network: $400* Inpatient Admission: In-Network $200* Out-of-Network: $300* Outpatient Surgery: In-Network $150* Out-of-Network: $250*
Network	PPO *(Hospitals and Surgery Centers)* | Traditional *(Physicians and Other Professional Providers; Facilities other than Hospitals and Surgery Centers)*
Deductible Waived For:	Diabetic Education Benefit (the first $250), Well-Child Care, Preventive Health Care, Hospice, Mammograms, and Prescription Drugs

Blue Cross and Blue Shield of Montana (BCBSMT) Provider Networks

Preferred Provider Organization (PPO) (In-Network) - 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 (In-Network) - 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 and 100% of hospitals in Montana participate in this network.

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

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

Finding Participating Providers - To locate Participating Providers and 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 health plan 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 http://provider.bcbs.com 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. This plan has an in-network deductible and a separate out-of-network deductible.

Out-of-Pocket Amount: The total amount of deductible, copayment and coinsurance that you would pay in a single benefit period. Once the out-of-pocket amount is met, the Plan pays 100% of the allowable fee on covered services that apply to the out-of-pocket amount. However, any amount you pay for balances owed to nonparticipating providers does not apply to the out-of-pocket amount. This plan has an in-network out-of-pocket amount and a separate out-of-network out-of-pocket amount.

Coinsurance: The percentage of the allowable fee payable by the Member for covered medical expenses. This plan has an in-network coinsurance and a separate out-of-network coinsurance.

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

Rating Factors and Trend: The following factors are used in setting rates: the income and claims experience for the 12 months prior to rating calculations for the category of product being rated, the benefit difference for the deductible and copayment relationship for the specific products in a product category, the projected claims, income, and enrollment for the next 12-month rating period, projected expenses for the plan of the next rating period, and/or age of the application or subscriber, industry, and risk characteristics. The trend of premium increases during the preceding five years is: 2009 - 15%, 2010 - 13%, 2011 - 13%, 2012 - 11%, 2013 - 13%.

Deductible and coinsurance apply to all services listed below, unless otherwise noted. This is only a summary of benefits. Benefits and general provisions described herein are subject to the terms of the Member Guide and Group Contract. Prior Authorization is not a guarantee of payment but is recommended for some services, supplies, treatments, and prescription drugs to help the Member identify potential expenses, payment reductions, or claim denials that may occur if these proposed services are not Medically Necessary or not a Covered Medical Expense. Refer to your Member Guide.

Professional Provider Services	Covered services include home and office calls, x-ray, lab, and other services provided by a 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, vaccinations, lactation services, a breast pump and certain contraceptives. Deductible and coinsurance do not apply.
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.
Maternity Services	Professional and facility services are processed under regular medical benefits.
Emergency Room Care	Services provided for accidental injury and emergency 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	10 visit maximum per benefit period.
Home Health Care	Up to 180 visits per benefit period.
Hospice	Deductible and coinsurance do not apply. Paid at 100% of the allowable fee.
Individual Therapies	Physical, occupational, speech, and cardiac rehabilitation therapies for outpatient professional and facility charges.
Rehabilitation Therapy	Inpatient and outpatient rehabilitation therapy services.
Durable Medical Equipment and Prostheses	Initial purchase, replacements, and repair.
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. Deductible and coinsurance do not apply. Paid at 100% of the allowable fee.
Autism Spectrum Disorder	Diagnosis and treatment of Autistic disorder, Asperger's disorder or pervasive developmental disorder. Applied Behavior Analysis (ABA) therapy is only available to members 0-18 years of age.
Mammograms	Deductible and coinsurance do not apply. Paid at 100% of the allowable fee.
Diabetic Education Benefit	Deductible and coinsurance do not apply to the first $250 per benefit period for outpatient services. After the first $250 in payment, deductible and coinsurance apply.
Prescription Drugs *Retail: 30-day supply* *Mail-Order: 90-day supply* *Extended Network: 90-day supply* *Deductible: Does not apply*	Copayments **Retail purchase:** $0 preferred generic; $10 non-preferred generic; $35 formulary; $75 non-formulary **Mail-order purchase:** $0 preferred generic; $20 non-preferred generic; $70 formulary; $150 non-formulary **Extended Supply Network:** $0 preferred generic; $30 non-preferred generic; $105 formulary; $225 non-formulary **Specialty Pharmaceuticals:** $150 copayment (30-day supply only) Payments for prescription drugs purchased at a non-participating pharmacy will be reduced by 50%, in addition to any copayment.

Members Rights-When requested by the Member or the Member's agent, BCBSMT is required to provide a summary of a Member's coverage for a specific health care service or course of treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or hospital exceeds $500.

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