MADISON COUNTY BLUEEDGE HSA PLUS PPO℠

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 2020

This plan does not have an Annual or Lifetime Plan Maximum

Deductible		Coinsurance		Out of Pocket Amount	
Individual	Family	In-Network	Out-of-Network	Individual	Family
$3,500	$7,000	100/0	100/0	$3,500	$7,000

Benefit Period	Contract Year (July 1 – June 30)
HSA Compatibility	This plan meets Federal requirements to be offered in conjunction with Health Savings Accounts (HSAs)
Deductible	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
Deductible Waived For:	**In and Out-of-Network:** Diabetic Education (the first $250); Well-Child Care **In-Network:** Preventive Health Care; Routine Mammograms **Out-of-Network:** The first $70 for Routine Mammograms

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

In-Network Providers – In-Network providers accept the BCBSMT allowable fee, in addition to the deductible, coinsurance and copayment, as payment in full for covered services. In-Network providers submit claims for the member and BCBSMT pays In-Network providers directly. The member will not be billed amounts over the deductible, coinsurance and copayment.

Subject to applicable laws and regulations, if an In-Network provider is not available to provide medically necessary covered services, the Member may obtain the covered services from an Out-of-Network provider at the In-Network benefit level; however, the Out-of-Network provider may balance bill the Member the difference between the allowable fee and their charge, in addition to any deductible, coinsurance and copayment.

Out-of-Network Providers - Nonparticipating Providers have not contracted with BCBSMT to provide services at negotiated rates, and out of pocket expenses can be significantly higher. These providers are under no obligation to submit claims for the member and may bill the member the difference between the allowable fee and their charge, in addition to any deductible, coinsurance and copayment.

Emergency Services - Services provided in a Hospital emergency department (emergency room) for an emergency medical condition which is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn fetus. These services pay as In-Network, even if provided Out-of-Network. An Out-of-Network provider may bill the difference between the allowable fee and their charge, in addition to any deductible, coinsurance and copayment.

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.

Out of Pocket Amount: The total amount of deductible and coinsurance that each Member would pay in a single benefit period. Once the out of pocket amount is met, the Plan pays 100% of the allowable fee on most covered services that would have applied to the out of pocket amount. However, any amount each Member pays for balances owed to nonparticipating providers does not apply to the out of pocket individual/family amount.

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

Rating Factors and Trend: The following rating factors are used: income and claims experience for the prior 12 months for the product being rated, the benefit difference for deductible, coinsurance and copayment for specific products in a category, projected claims, income and enrollment for the next 12-month rating period, projected expenses for the next rating period, and/or age of the applicant or subscriber, industry, and risk characteristics. The trend of premium increases during the preceding five years is: 2015 – 11%, 2016 – 10%, 2017 – 8.5%, 2018 – 6%, 2019 – 1.9%.

Your estimated premium will be _____.

The Appeals section in the Group Contract and Member Guide contains information regarding utilization review procedures, including procedures for obtaining review of adverse determinations, and the Member's rights with respect to those procedures.

Deductible and coinsurance apply for 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. Preauthorization is not a guarantee of payment but is required 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.

BENEFIT HIGHLIGHTS - BLUEEDGE HSA PLUS PPO

Professional Provider Services	Home and office calls, surgery, anesthesia, diagnostic lab and x-ray, 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 & Screening 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, immunizations, vaccinations, lactation services, breast pump (maximum of one electric), certain contraceptives and certain tobacco cessation products. Deductible and coinsurance do not apply to In-Network services which are paid at 100% of the allowable fee. Deductible and coinsurance apply to Out-of-Network services except for the first $70 for Out-of-Network routine mammograms. Deductible does not apply to Out-of-Network Well-Child Care.		
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 and Acupuncture Services	Chiropractic: 10 visit maximum per benefit period. Acupuncture: 12 visit maximum 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.		
Durable Medical Equipment and Prostheses	Initial purchase, replacement, and repair.		
Substance Use Disorder	Processed under regular medical benefits.		
Mental Illness	Processed under regular medical benefits.		
Autism Spectrum Disorder	Diagnosis and treatment of Autistic disorder, Asperger's disorder, or pervasive developmental disorder. Applied Behavioral Analysis (ABA) therapy is only available to members 0 – 18 years of age.		
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 **Deductible:** Applies The member must pay the difference between a brand name drug and the generic equivalent, in addition to the copayment, if the member chooses a brand name drug when a generic is available. This amount will not apply to the Out of Pocket Amount.	Processed under regular medical benefits. Deductible does not apply to preventive prescription drugs. Payment for Prescription Drugs purchased at a nonparticipating pharmacy will be reduced by 50% in addition to the nonparticipating pharmacy coinsurance. This 50% benefit reduction does not apply to the Out of Pocket Amount. Amounts paid at a Value or a Participating Pharmacy apply to the In-Network Deductible and Out of Pocket Amount. Amounts paid at a nonparticipating pharmacy apply to the Out-of-Network Deductible and Out of Pocket Amount.		
	Value Participating Pharmacy	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Retail: 30-day supply	After deductible, None	After deductible, None	After deductible, None
Retail: 90-day supply	Only available from a Value Participating Pharmacy: After deductible, None		
Mail Order: 90-day supply	Only available at an approved Mail Order Pharmacy: After deductible, None		
Specialty Medications: 30-day supply	After deductible, None		

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.