S & K TECHNOLOGIES, INC.
BLUE DIMENSIONS
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 2016

This plan does not have an Annual or Lifetime Plan Maximum

Office Visits	Deductible	Coinsurance	Out-of-Pocket Amount
For In-Network Professional Providers	Amount reflects Individual Deductible. Family = 2X Individual.	In-Network Out-of-Network	Must exceed Deductible. Amount reflects Individual Out-of-Pocket. Family = 2X Individual
0 $35 PCP 0 $55 Specialist	0 $2,000	0 70/30 55/45	0 $4,000
For Out-of-Network Professional Providers Deductible and coinsurance apply			

Benefit Period	Calendar Year (January 1 – December 31)
Deductible Waived For: *Note: Prescription drugs have their own deductible.*	**In and Out of Network:** Diabetic Education Benefit (the first $250); Hospice; Emergency Room; Well-Child Care. **In Network:** Preventive Health Care; Routine and Diagnostic Mammograms; Professional Provider Services for Accidents, Chemical Dependency, Chiropractic Care, Diagnostic and Education Services, Hospital Outpatient Care, Mental Illness, Newborn Initial Care, Office Visits, Severe Mental Illness, Outpatient Surgery Center and Outpatient Therapies **Out of Network:** The first $70 for Routine Mammograms

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

Preferred Provider Organization (PP) (In-Network) - An innovative health partnership developed by BCBSMT and our Preferred Hospital Providers to offer 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 and facility providers, other than hospitals and surgery centers, 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 and coinsurance, 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 - 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 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 Blue Cross and Blue Shield Association website at hhttp://provider.bcbs.com or call 1-800-810-BLUE (2583).

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

Deductible, coinsurance and copayment 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 - BLUEDIMENSIONS

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 Including Mammograms and Well-Child 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 two electric), certain contraceptives and certain tobacco cessation products. Deductible, coinsurance and copayment 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	$100 copayment for accidental injury and medical emergency. Deductible and coinsurance do not apply.
Transplants	Processed under regular medical benefits.
Convalescent Home	Skilled nursing facility, transitional care units, and extended care facilities. Up to 90 days per benefit period.
Chiropractic and Acupuncture Services	Chiropractic: 36 visit maximum per benefit period. Acupuncture: 36 visit maximum per benefit period.
Home Health Care	Processed under regular medical benefits.
Hospice	Inpatient and outpatient care, home care, skilled nursing, and counseling. 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, replacement, and repair.
Chemical Dependency	Processed under regular medical benefits.
Mental Illness	Mental Illness, including Severe Mental Illness, is 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 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.	$150 deductible per Family Member (does not apply to generics), then: Retail purchase, 30-day supply: $10 generic; $40 preferred brand name; 60% up to a maximum of $200 non-preferred Mail-order purchase, 90-day supply: $20 generic; $80 preferred brand name; 60% up to a maximum of 400 non-preferred Extended Supply Network, 90-day supply: $30 generic; $120 preferred brand name; 60% up to a maximum of $600 non-preferred Specialty Pharmaceuticals, 30-day supply: $100 generic and non-preferred brand name, $200 non-preferred brand name Payment for Prescription Drugs purchased at a nonparticipating pharmacy will be reduced by 50% in addition to any copayment. Specialty Pharmaceuticals, when purchased at a nonparticipating pharmacy, are not covered. Mail Order is only available through the Mail Order Pharmacy Network.

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.

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 expenses.

Out-of-Pocket Amount: The total amount of deductible, coinsurance and copayments 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 and the Out-of-Network pharmacy 50% benefit reduction do not apply to the out-of-pocket individual/family amount.

Rating Factors and Trend: The following factors are used in setting rates: the income and claims experience for the 12 months prior to rate 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 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 : 2011 – 13%, 2012 – 11%, 2013 – 11%, 2014 – 11%, 2015 – 11%.

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 or clinic or hospital exceeds $500.