S & K TECHNOLOGIES, INC.
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 2016

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	Calendar Year (January 1 – December 31)
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

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 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, 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 may 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 hhtp://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 and the Out of Network pharmacy 50% benefit reduction do 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 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 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: 2011 – 13%, 2012 – 11%, 2013 – 11% 2014 – 11%, 2015 - 11%.

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 two 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 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	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.
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	Processed under regular medical benefits except for preventive prescription drugs. Preventive Medications Deductible does not apply Retail Purchase 30-day supply: $10 generic; $40 preferred brand name; 60% up to a maximum of $200 non-preferred brand name Mail-order purchase 90-day supply: $20 generic; $80 preferred brand name; 60% up to a maximum of $400 non-preferred brand name Extended Supply Network 90-day supply: $30 generic; $120 preferred brand name; 60% up to a maximum of $600 Non-preferred brand name Payment for Prescription Drugs purchased at a nonparticipating pharmacy will be reduced by 50% Specialty Pharmaceuticals, when purchased at a nonparticipating pharmacy, are not covered. Mail Order is only available through the Mail Order Pharmacy Network.

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.

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