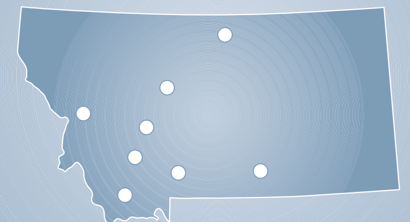
2017-2018 STUDENT HEALTH INSURANCE PLAN

OUTLINE OF COVERAGE

Montana State University **Billings**
▪
Montana State University **Bozeman**
▪
Montana State University **Great Falls College**
▪
Montana State University **Northern**



University of Montana **Helena College**
▪
University of Montana **Missoula**
▪
University of Montana **Montana Tech**
▪
University of Montana **Western**

Students 8/2017

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

WHO NEEDS HEALTH INSURANCE?

Everyone does, including students. Good health is essential to your academic success, and adequate insurance makes sure you get the care you need to maintain your good health. Unexpected medical bills can also threaten your ability to complete your education if you are uninsured or have inadequate coverage.

ARE YOU SURE YOU'RE COVERED?

You may not be. An out-of-state student covered by a Health Maintenance Organization or other managed care program at home may have limited benefits in the state of Montana. Often students who are over age 26 are no longer covered as dependents under a parent's health insurance plan. Finally, some students declare financial independence to gain eligibility for financial aid programs. This may mean the student is ineligible for coverage as a dependent under a parent's plan regardless of the student's age. Check your current plan carefully to make sure you're covered.

STUDENT HEALTH PLAN NOTICE

Your student health insurance coverage includes an annual limit of $10,000 on private duty nursing. If you have questions or concerns about this notice, contact Customer Service at 1-855-267-0214. You may be eligible for coverage under a parent's employment-based group health plan or individual health insurance if you are under age 26. Contact the plan administrator of the parent's employer plan or the issuer of the parent's individual health insurance for more information.

NEED MORE INFORMATION?

A list of participating providers and other information can be accessed on the Blue Cross and Blue Shield of Montana website at:
www.bcbsmt.com

QUESTIONS?

Please call the Student Insurance Office on your campus or Blue Cross and Blue Shield of Montana at 1-855-267-0214.

THE STUDENT HEALTH INSURANCE PLAN

All students are required to have health insurance. For students without adequate coverage, the University is pleased to offer the special program described in this brochure. This plan has been developed especially for students by Blue Cross and Blue Shield of Montana (BCBSMT) who is committed to assisting college health professionals and administrators in providing students access to affordable health care.

HOW DOES THE STUDENT INSURANCE PLAN WORK?

This plan provides coverage for injuries and illnesses, on or off campus. It also includes special cost-saving features to keep the coverage as affordable as possible.

1. ELIGIBILITY

If you are a fee-paying student attending credit courses at a participating campus, you are eligible for the insurance. The insurance will begin on the first day of the semester provided that payment is made as required within the enrollment period.

All campuses: All students who have enrolled for six credit hours or more will automatically be enrolled for the entire semester unless a waiver form is completed and returned to the campus insurance representative within the prescribed waiver period. The insurance charge will be assessed each Fall and Spring Semester.

International students, regardless of their number of credit hours, are required to purchase Health Insurance while residing in the United States. The Student Health Insurance Plan coverage is automatic for each period of enrollment. You may waive participation in the Student Health Insurance Plan on the same basis as other students (proof of coverage in the United States).

Students who are enrolled for less than six credit hours are not eligible for the Student Health Insurance Plan. Any exceptions to this provision must have the prior authorization from the Student Health Services Office or the Campus Office responsible for Student Insurance.

2. ENROLLMENT

A specified period of time will be allowed at the beginning of each semester for enrolling in the Plan or waiving coverage. For the Fall and Spring semesters, the enrollment/waiver period will begin on the first day of scheduled classes each semester and end 15 class days later.

Eligible students will not be allowed to enroll in the Plan after the applicable enrollment/waiver period unless proof is furnished that the student became ineligible for coverage under another group insurance plan during the 31 days immediately preceding the date of the request for late enrollment in the Student Health Insurance Plan. In such cases, the cost and the effective date will be the same as it would have been at the beginning of that period.

3. REFUNDS

Refunds will be made upon the entry of any insured person into the armed forces of any country. A prorated refund will be returned to the appropriate campus.

Students who withdraw for nonmedical reasons during the first 15 class days of a semester are not eligible for the Student Health Insurance Plan for that semester. Students must notify the Student Health Service Office (or at MT Tech, the Student Life Programs Office) of such withdrawal and the entire cost of the coverage for that semester will be refunded. Such a student will not be entitled to any benefits during the days described above and no claims will be honored.

No other refunds will be issued.

For nonmedical withdrawals after the first 15 class days of a semester, coverage will continue to the end of the semester and no refunds will be issued.

THIS IS NOT YOUR CERTIFICATE

This Outline of Coverage is not a contract with Blue Cross and Blue Shield of Montana. It is a summary of benefits and limitations. If there is any difference between this Outline of Coverage and the group contract, the provisions of the group contract will govern. A complete description of benefits and limitations is on the Student Web site or at www.university.bcbsmt.com. If a printed Member Guide is desired, please call the Student Benefit number at 1-855-267-0214.

OTHER IMPORTANT INFORMATION

IN-NETWORK PROVIDERS

One of the biggest advantages of the Plan is access to the Blue Cross and Blue Shield of Montana network of participating providers. These doctors, and other providers have agreed to accept, in addition to any deductibles, copayment, and coinsurance, the allowable fee of Blue Cross and Blue Shield of Montana as payment in full for covered services. When you use a participating professional provider, you will not be responsible for any charges in excess of the allowable fee, even if your provider normally charges more. You are still free to choose a nonparticipating provider, however, you will have to pay any difference between the Plan's allowable fee and the provider's charges.

A PPO Network is utilized under this benefit plan. PPO hospitals and surgery centers are available throughout Montana and the Member receives the In-Network Benefit by utilizing this PPO Network. If the Member obtains services or supplies from a non-PPO Network provider, the member will responsible for a the out-of-network deductible, coinsurance and out of pocket amount.

SERVICES AVAILABLE ON CAMPUS

For services received from available campus programs, please refer to your campus insert.

PREAUTHORIZATION

The purpose of Preauthorization is to make sure you receive the quality of care you need in the most cost-efficient setting. Notify BCBSMT if you need to have inpatient care, outpatient surgery or other major medical procedures as soon as your physician recommends or schedules such services. Obtaining Preauthorization is not a guarantee of payment by The Plan.

Preuthorization is required for certain procedures to avoid unexpected expenses to you. This process will help you to identify potential expenses to you, assure coverage before having services and help you find participating providers.

Preauthorization is required for the following services. However, refer to your Member Guide for a more detailed list.

- Home health care services
- Hospice services
- Home infusion therapy
- Inpatient admissions

If you do not obtain preauthorization, a retrospective review will be performed after the claims have been submitted to determine whether or not the services, supplies, or treatment were Medically Necessary and performed in the appropriate setting. You will be responsible for charges for any services, supplies, or treatment not performed in the appropriate setting or not Medically Necessary.

EXCLUSIONS AND LIMITATIONS - BRIEF SUMMARY

Benefits are not payable for the following services under this Plan. These limitations and exclusions are described in more detail in the Member Guide.

1. Services not listed or described, and any services determined by Blue Cross and Blue Shield of Montana to be experimental, Routine*, preventive, or not medically necessary for treatment of an illness, injury or pregnancy, except as specifically included.
2. Services for injuries or diseases related in any way to your job.
3. Services for artificial insemination, in-vitro fertilization, or any type of artificial or surgical means of conception.
4. Services for, or related to, cosmetic surgery unless due to injury received while covered.
5. Services for eyeglasses, vision training or therapy, radial keratotomy, hearing aids, or examinations for the fitting or prescription of eyeglasses or hearing aids, except as specifically included in Pediatric Vision.
6. Services for diseases contracted or injuries sustained as a result of any act of war (declared or undeclared).
7. Expense due to participation in intercollegiate sports.
8. Services provided normally without charge by any Campus Student Health Service, or by any person employed, or retained by the University, or services covered or provided by the student medical fee.
9. Prescription drugs prescribed for weight loss or stop-smoking aids, except smokings cessation aids/medication, as required by the Affodable Care Act.
10. Services for dependents.

* Routine: Examinations or services provided when there is no objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any injury or illness.

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: 2012 - 9%, 2013 - 11%, 2014 - 8%, 2015 - 8%, 2016 - 7.4%, 2017 - %8.4.

BENEFITS SUMMARY

Plan Year ..... Academic Year – 8/1/17 through 7/31/18

Individual Deductible ..... $500 per Plan Year – In-Network; $1,000 per Plan Year – Out-of-Network

Individual Annual Maximum Out of Pocket Expense ..... $6,850 per Plan Year – In-Network; $13,700 per Plan Year – Out-of-Network
(Deductible plus Copayment and Coinsurance)

Your Coinsurance: ..... After you have satisfied the applicable deductible, you pay a certain percentage of the Allowable Fee. This is your Coinsurance. The Allowable Fee is the maximum amount Blue Cross and Blue Shield of Montana will pay a provider for a covered service. See In-Network Providers.

*** The In-Network and Out-of-Network Deductible and Out-of-Pocket amounts are separate amounts and one does not accumulate to the other.*

Services received at a Student Health Center are payable at 100% of the Allowable Fee.

COVERED SERVICES	COINSURANCE
Hospital Facility Services – *Inpatient and Outpatient* Bed, board, general nursing services, ancillary services, surgery, chemotherapy, radiation therapy, and dialysis	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Surgery Services Inpatient surgery, outpatient surgery, inpatient medical services, outpatient medical services, and anesthesia for covered surgery	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Convalescent Home – Skilled Nursing Facility, Extended Care and Transitional Care Units (60 day maximum)	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Emergency Room Services – Emergency Conditions (In and Out-of-Network)	Facility Room Charges - $100 copayment in addition to 20% of the Allowable Fee, *not subject to deductible* Other Facility Charges - 20% of the Allowable Fee, *not subject to deductible* Physician Charges - 20% of the Allowable Fee, *not subject to deductible*
Emergency Room Services – Non-Emergency Conditions (In Network)	Facility Room Charges - $100 copayment in addition to 20% of the Allowable Fee, *not subject to deductible* Other Facility Charges - 20% of the Allowable Fee Physician Charges - 20% of the Allowable Fee
Emergency Room Services – Non-Emergency Conditions (Out-of-Network)	Facility Room Charges - 40% of the Allowable Fee Other Facility Charges - 40% of the Allowable Fee Physician Charges - 40% of the Allowable Fee
Primary Care Physician Office Visit	$20 copayment - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Specialist Office Visit	$40 copayment - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Professional Surgical/Medical Services – Inpatient surgery, inpatient medical services, outpatient medical services, and anesthesia for covered surgery	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Professional Outpatient Diagnostic Services – Radiology, Ultrasound and Nuclear Medicine Laboratory and Pathology, ECG, EEG and other Electronic Diagnostic Medical Procedures	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Professional Outpatient Diagnostic Services (Hi-Tech) – CAT Scan, MRI, PET Scan	$100 copayment - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Professional Outpatient Therapy Services – Radiation Therapy, Chemotherapy, Dialysis Treatment, Physical Therapy, Respiratory Therapy, Occupational Therapy, Speech Therapy, IV Therapy	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Maternity Care Services	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Immunizations	0% of the Allowable Fee - *In and Out-of-Network* *(Not subject to deductible)*
Autism Spectrum Disorders – Applied Behavior Analysis is only available for members under 19 years of age	$40 copayment - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Preventive Healthcare, including Well Child services and routine mammograms *(One breast pump per birth event)*	0% of the Allowable Fee - *In and Out-of-Network* *(Not subject to deductible)*
Chemical Dependency/Substance Abuse and Mental Illness Treatment – Inpatient and Outpatient Services	$20 copayment/office visit or 20% of the Allowable Fee/other services - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Ambulance Services	20% of the Allowable Fee - *In and Out-of-Network*
Private Duty Nursing Services *($10,000 maximum benefit per Plan Year)*	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Dental Services – Related to accidental injury of natural teeth	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Transplants	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Rehabilitation Therapy	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Durable Medical Equipment, Prosthetic Appliances, and Medical Supplies	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Home Health Care Services *(180 visits maximum per Plan Year)*	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Hospice Care	20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Pediatric Vision – For members under 19 years of age	Routine Exam: 0% of the Allowable Fee - *In-Network* 0% of the Allowable Fee - *Out-of-Network* 1 pair of glasses or 2 boxes of contacts: 20% of the Allowable Fee - *In-Network* 40% of the Allowable Fee - *Out-of-Network*
Prescription Drugs – 30 day supply (Retail), 90 day supply (Mail Order) 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 drug is available. Specialty pharmaceuticals are available for a 30 day supply at the retail copayment amount.	Retail: $15 Generic, $30 Preferred Brand, $50 Non-Preferred Brand Mail Order: $45 Generic, $90 Preferred Brand, $150 Non-Preferred Brand