

# Montana Affordable Care Plan (MAC Plan)

## 2010 Outline of Coverage

### General Information

MAC Plan	
Deductible	\$2,500
Coinsurance	
In network	70/30
Out of network	50/50
Maximum Annual Liability	\$5,950
Lifetime Maximum Benefit	\$2,000,000
Benefit Period	Calendar Year (January 1 through December 31)
Preventive Benefit	Pays 100% of the allowable fee up to \$300 Per benefit period for Preventive Health Care
Deductible Waived for: <ul style="list-style-type: none"> <li>• Diabetic Education</li> <li>• Durable Medical Equipment</li> <li>• Hospice</li> <li>• Mammograms</li> <li>• Newborn Initial Care and Lifesaving Procedures</li> <li>• Preventive Health Care</li> <li>• Prosthetics</li> <li>• Rehabilitation Therapy</li> <li>• Well-Child Care (through age 7)</li> </ul>	

\* **Maximum Annual Liability** is the total amount you would pay in a single benefit period. Once the total of your deductible and coinsurance reaches this amount, the MAC Plan pays 100% of the allowable fee on most covered services. Any amount you pay for balances owed to nonparticipating providers does not apply to the Maximum Annual Liability.

### The Blue Cross and Blue Shield of Montana Participating and HealthLink PPO Provider Networks ... An Important Feature

<p><b>BCBSMT Participating and HealthLink PPO Providers</b> MCHA's PPO (Preferred Provider Organization) options utilize the BCBSMT Healthlink PPO and the BCBSMT Participating Provider Networks. When you receive services from a BCBSMT Participating Professional or Facility Provider (other than hospitals or surgery centers) or a Healthlink PPO Network hospital or surgery center, you receive the most value from your health care benefits while limiting your out-of-pocket expenses.</p> <p><b>Participating Providers</b> accept the allowable fee as their full reimbursement, so Plan payment, deductible, and coinsurance is their full reimbursement. <b>They will NOT bill you for charges in excess of the allowable fee for covered services.</b></p>	<p><b>Nonparticipating Providers</b> Nonparticipating providers have not contracted with BCBSMT. You will receive payment for claims received from a nonparticipating provider. These providers are under no obligation to send claims in for you. Payment for services of <b>nonparticipating providers</b> is made directly to you.</p> <p><b>If you use a non-PPO hospital or surgery center or a nonparticipating provider, a higher coinsurance will apply to those services.</b> Nonparticipating providers can bill you the difference between the allowable fee and their total charge, and any deductible and coinsurance, potentially making your out-of-pocket expenses significantly higher.</p>
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### Finding Participating Providers

Fortunately, a majority of health care providers in Montana are participating providers. To find the participation status of a provider, check our on-line provider directory at [www.bcbsmt.com](http://www.bcbsmt.com) or contact Customer Service at 1.800.447.7828. Be sure to have your subscriber identification number available when you call.

### Out-of-State and Worldwide Services

The "BlueCard Program" gives Blue Cross and Blue Shield of Montana policyholder access to Participating Provider arrangements between Blue Cross and Blue Shield Plans in other states and providers in those states. If you choose a Participating Provider in another state for health care services, you may have discounts and hold-harmless provisions (no balance billing except for your deductible and coinsurance) available to you. To find out-of-state or out-of-country Participating Providers, call the toll-free BlueCard Access line at 1.800.810.BLUE (2583) or check via the Internet at [www.bcbs.com/healthtravel/](http://www.bcbs.com/healthtravel/).

**Prior Authorization**, which is not a guarantee of payment, is recommended for some services, supplies, treatments and drugs to help the member identify potential expenses, payment reductions, or claim denials the Member may have if these proposed services, etc. are not Medically Necessary or not a Covered Medical Expense. Examples of such services are: Hospice and Durable Medical Equipment over \$500. Refer to your Policy.

# Benefit Highlights (for more detailed information, please refer to your Policy)

**Deductible and coinsurance apply to all services listed below unless otherwise noted.**

BENEFIT	COVERED SERVICE
<b>PROFESSIONAL PROVIDER SERVICES</b>	Covered services include home and office calls, x-ray, lab, and other services provided by a Participating Professional Provider.
<b>INPATIENT HOSPITAL</b>	Room and board, special care units, ancillary charges, and transplant coverage.
<b>OUTPATIENT HOSPITAL</b>	Accidental injury, x-ray and lab, surgery, chemotherapy, respiratory therapy, radiation therapy, medical emergency, surgery center, and other services.
<b>TRANSPLANTS</b>	\$10,000 for ambulance or air transport to the transplant site per transplant. \$25,000 maximum for organ procurement per transplant. \$500,000 lifetime maximum.
<b>CONVALESCENT HOME</b>	Skilled nursing facility, transitional care units, and extended care facilities. Up to 60 days per benefit period.
<b>CHIROPRACTIC SERVICES</b>	35 treatments per benefit period. \$25 allowance per treatment
<b>HOME HEALTH CARE</b>	Up to 180 visits per benefit period.
<b>HOSPICE</b>	Paid at 100%. Deductible and coinsurance waived.
<b>OUTPATIENT THERAPIES</b>	Physical, occupational, speech and cardiac rehabilitation therapies. \$4,000 maximum per benefit period, combined, for outpatient professional and facility charges.
<b>REHABILITATION THERAPY</b>	\$100,000 lifetime maximum per policyholder for inpatient and outpatient rehabilitation therapy services
<b>DURABLE MEDICAL EQUIP AND PROSTHESES</b>	Initial purchase and replacement. Prior authorization is recommended if charges are over \$500.
<b>MENTAL ILLNESS</b> <b>OUTPATIENT</b> <b>INPATIENT</b>	<i>Note: Severe mental illness is processed under regular medical benefits.</i> \$2,000 maximum per benefit period. 21 days for professional, hospital and/or freestanding inpatient facility charges, per benefit period <b>combined with Chemical Dependency</b> . Inpatient day maximum applies. Plan Notification is recommended.
<b>AUTISM SPECTRUM DISORDER</b>	Diagnosis and Treatment of Autistic Disorder, Asperger's disorder or pervasive developmental disorder. Habilitative or rehabilitative care, including, but not limited to, professional, counseling and guidance services and treatment programs; Applied Behavior Analysis (ABA), also known as Lovaas therapy; discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention; medications; psychiatric or psychological care; therapeutic care provided by a speech-language pathologist, audiologist, occupational therapist or physical therapist. The following maximums apply: \$50,000 a year to a child 8 years of age or younger; \$20,000 a year for a child 9 years of age through 18 years of age.
<b>CHEMICAL DEPENDENCY</b> <b>OUTPATIENT</b> <b>INPATIENT</b>	\$1,000 per 12 months for outpatient services. 21 days for professional, hospital and/or freestanding inpatient facility charges, per policyholder, per benefit period, <b>combined with Mental Illness</b> . \$4,000 maximum benefit per benefit period. \$8,000 lifetime maximum benefit.
<b>WELL-CHILD CARE</b>	Exams, lab tests and routine immunizations from birth through age 7. Deductible does not apply.
<b>MAMMOGRAMS</b>	Paid at 100% of the actual charge, up to a maximum of \$100. Deductible and coinsurance apply to any balance after the first \$100 is paid.
<b>DIABETIC EDUCATION BENEFIT</b>	Up to \$250 per benefit period for outpatient services, deductible does not apply. After first \$250 in services, deductible and coinsurance apply.
<b>PREVENTIVE HEALTH CARE</b> <i>*Routine – Examinations or services provided when there is not objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any injury or illness</i>	Routine* services, available only for Members age 8 and older are: Pap Tests, related lab charges and related office visit; Proctoscopies, sigmoidoscopies, colonoscopies or hemocults and related office calls; Immunoassay for tumor antigen or prostate specific antigen (PSA) and related office call; Physical examinations and related tests as recommended for routine physical exams; Routine diagnostic x-ray and laboratory service, including but not limited to chemistry screens, cholesterol and other blood fat tests and thyroid (T4) test; Immunizations and vaccinations. Deductible does not apply.
<b>PRESCRIPTION DRUGS</b>	No deductible
	<u>Copayment/Coinsurance</u> <u>Maximum Copayment</u>
Retail Pharmacy Prescription (34-day supply)	Generic    \$10    None Brand Name (Formulary)                      \$35 + 20% of remaining cost                      \$200 per prescription Brand-name (Non Formulary)                      \$50 + 30% of remaining cost                      \$300 per prescription
Mail-Order Prescription (90-day supply)	Generic    \$20    None Brand Name (Formulary)                      \$70 + 20% of remaining cost                      \$400 per prescription Brand-name (Non Formulary)                      \$100 + 30% of remaining cost                      \$600 per prescription

## MAC Plan

*This information is only a summary of benefits. Benefits and general provisions described herein are subject to the terms of the Policy.*