

MCHA Traditional PPO Plan

Outline of Coverage

2011

General Information

Traditional PPO 10000	
Deductible	\$10,000
Coinsurance	
In network	80/20
Out of network	60/40
Maximum Annual Liability	\$15,000
Annual Maximum Benefit	\$750,000
Benefit Period	Calendar Year (January 1 through December 31)
Deductible Waived for: <ul style="list-style-type: none"> <li style="width: 50%;">• Diabetic Education <li style="width: 50%;">• Newborn Initial Care and Lifesaving Procedures <li style="width: 50%;">• Hospice <li style="width: 50%;">• Preventive Health Care <li style="width: 50%;">• Mammograms <li style="width: 50%;">• Well-Child Care 	

* **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 MCHA Traditional PPO Plan pays 100% of the allowable fee on most covered services. Any amount you pay for balances owed to nonparticipating providers and prescriptions does not apply to the out-of-pocket amount.

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

<p>BCBSMT Participating and HealthLink PPO Providers 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>Participating Providers accept the allowable fee as their full reimbursement, so Plan payment, deductible, and coinsurance is their full reimbursement. They will NOT bill you for charges in excess of the allowable fee for covered services.</p>	<p>Nonparticipating Providers 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 nonparticipating providers is made directly to you.</p> <p>If you use a non-PPO hospital or surgery center or a nonparticipating provider, a higher coinsurance will apply to those services. 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>
---	--

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, or contact Customer Service at 1.800.447.7828. Be sure to have your subscriber ID 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/.

The Exclusion Period for Preexisting Conditions is 12 months. If you had Creditable Coverage that was continuous within 30 days of your Certificate of Creditable Coverage being issued, that coverage may be credited toward the exclusion period.

Note: The exclusion period for preexisting conditions does not apply to Policyholders under 19 years of age.

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
PROFESSIONAL PROVIDER SERVICES	Covered services include home and office calls, x-ray, lab, and other services provided by a Participating Professional Provider.
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.
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.
HOME HEALTH CARE	Up to 180 visits per benefit period.
HOSPICE	Paid at 100% of the allowable fee. Deductible and coinsurance do not apply.
OUTPATIENT THERAPIES	Physical, occupational, speech and cardiac rehabilitation therapies.
REHABILITATION THERAPY	Processed under regular medical benefits.
AUTISM SPECTRUM DISORDER	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.
DURABLE MEDICAL EQUIPMENT AND PROSTHESES	Initial purchase and replacement. Prior authorization is recommended if charges are over \$500.
WELL-CHILD CARE	Exams, lab tests and routine immunizations. Paid at 100% of the allowable fee. Deductible and coinsurance do not apply.
MAMMOGRAMS	Paid at 100% of the allowable fee. Deductible and coinsurance do not apply.
DIABETIC EDUCATION BENEFIT	Up to \$250 per benefit period for outpatient services, deductible and coinsurance do not apply. After first \$250 in services, deductible and coinsurance apply.
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 & Screenings 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, colonoscopies, immunizations and vaccinations. Paid at 100% of the allowable fee.
PRESCRIPTION DRUGS	No deductible
	<u>Copayment/Coinsurance</u>
Retail Pharmacy Prescription (34-day supply)	Generic \$10 Brand Name (Formulary) \$35 + 20% of remaining cost Brand-name (Non Formulary) \$50 + 30% of remaining cost
	<u>Maximum Copayment</u>
Mail-Order Prescription (90-day supply)	Generic None Brand Name (Formulary) \$400 per prescription Brand-name (Non Formulary) \$600 per prescription

MCHA Traditional PPO Plan

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