

# MCHA Traditional Indemnity Plan

## Outline of Coverage

2011

### General Information

Traditional Plan	
Deductible	\$1,000
Coinsurance	80/20
Maximum Annual Liability	\$5,000
Annual Maximum Benefit	\$750,000
Benefit Period	Calendar Year (January 1 through December 31)
Deductible Waived for:	
<ul style="list-style-type: none"><li>• Diabetic Education</li><li>• Hospice</li><li>• Mammograms</li></ul>	<ul style="list-style-type: none"><li>• Newborn Initial Care and Lifesaving Procedures</li><li>• Preventive Health Care</li><li>• Well-Child Care</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 MCHA Traditional 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 Provider Network ... An Important Feature

BCBSMT Participating Providers	Nonparticipating Providers
<p>A BCBSMT participating provider is either an individual (e.g., physician, physical therapist, nurse practitioner) or a facility (e.g., hospital) that has contracted with BCBSMT to provide services to our members.</p> <p>Participating providers accept the BCBSMT allowable fee plus any deductible and coinsurance as payment in full for covered services. There's no billing to you over your coinsurance and deductible amount. BCBSMT sends payment directly to participating providers.</p>	<p>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. Most importantly, nonparticipating providers are subject to a differential. This means that BCBSMT reduces the allowable fee by the following amounts before we calculate your benefits:</p> <ul style="list-style-type: none"><li>• Professional Providers (e.g., doctors, physical therapists, nurse practitioners, radiologists) are subject to a 10% differential.</li><li>• Facility Providers (e.g., hospitals, hospice, home health) are subject to a 10% differential.</li></ul> <p>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](http://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/](http://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											
<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, surgicenter, and other services.											
<b>TRANSPLANTS</b>	Processed under regular medical benefits.											
<b>CONVALESCENT HOME</b>	Skilled nursing facility, transitional care units, and extended care facilities. Up to 60 days per benefit period.											
<b>HOME HEALTH CARE</b>	Up to 180 visits per benefit period.											
<b>HOSPICE</b>	Paid at 100% of the allowable fee. Deductible and coinsurance do not apply.											
<b>OUTPATIENT THERAPIES</b>	Physical, occupational, speech and cardiac rehabilitation therapies.											
<b>REHABILITATION THERAPY</b>	Processed under regular medical benefits.											
<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>DURABLE MEDICAL EQUIPMENT AND PROSTHESES</b>	Initial purchase and replacement. Prior authorization is recommended if charges are over \$500.											
<b>WELL-CHILD CARE</b>	Exams, lab tests and routine immunizations. Paid at 100% of the allowable fee. Deductible and coinsurance do not apply.											
<b>MAMMOGRAMS</b>	Paid at 100% of the allowable fee. Deductible and coinsurance do not apply.											
<b>DIABETIC EDUCATION BENEFIT</b>	Up to \$250 per benefit period for outpatient services, deductible and coinsurance do not apply. After first \$250 in services, deductible and coinsurance apply.											
<b>PREVENTIVE HEALTH CARE</b>	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.											
<b>PRESCRIPTION DRUGS</b>	No deductible											
	<table border="0"> <thead> <tr> <th></th> <th style="text-align: center;"><u>Copayment/Coinsurance</u></th> <th style="text-align: center;"><u>Maximum Copayment</u></th> </tr> </thead> <tbody> <tr> <td>Retail Pharmacy Prescription (34-day supply)</td> <td>Generic Brand Name (Formulary) Brand-name (Non Formulary)</td> <td>\$10 \$35 + 20% of remaining cost \$50 + 30% of remaining cost</td> <td>None \$200 per prescription \$300 per prescription</td> </tr> <tr> <td>Mail-Order Prescription (90-day supply)</td> <td>Generic Brand Name (Formulary) Brand-name (Non Formulary)</td> <td>\$20 \$70 + 20% of remaining cost \$100 + 30% of remaining cost</td> <td>None \$400 per prescription \$600 per prescription</td> </tr> </tbody> </table>		<u>Copayment/Coinsurance</u>	<u>Maximum Copayment</u>	Retail Pharmacy Prescription (34-day supply)	Generic Brand Name (Formulary) Brand-name (Non Formulary)	\$10 \$35 + 20% of remaining cost \$50 + 30% of remaining cost	None \$200 per prescription \$300 per prescription	Mail-Order Prescription (90-day supply)	Generic Brand Name (Formulary) Brand-name (Non Formulary)	\$20 \$70 + 20% of remaining cost \$100 + 30% of remaining cost	None \$400 per prescription \$600 per prescription
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*This information is only a summary of benefits. Benefits and general provisions described herein are subject to the terms of the Policy.*