

MADISON COUNTY BLUE DIMENSIONS PPO



**BlueCross BlueShield
of Montana**

To learn more, call BlueCross and BlueShield of Montana at 800.447.7828 or your local agent.
www.bcbsmt.com

Outline of Coverage 2020 This plan does not have an Annual or Lifetime Plan Maximum

Office Visits	Deductible	Coinsurance		Out of Pocket Amount
For In-Network Professional Providers	Amount reflects Individual Deductible. Family = 2X Individual	In-Network	Out-of-Network	Must exceed Deductible. Amount reflects Individual Out of Pocket. Family = 2X Individual
o \$25	o \$2,000	o 80/20	65/35	o \$4,000
For Out-of-Network Professional Providers, Deductible and coinsurance apply				

Benefit Period	Contract Year (July 1 – June 30)
Deductible Waived For: <i>Note: Prescription drugs have their own deductible.</i>	In and Out-of-Network: Diabetic Education Benefit (the first \$250); Hospice; Emergency Room; Well-Child Care. In-Network: Preventive Health Care; Routine and Diagnostic Mammograms; Professional Provider Services for Accidents, Substance Use Disorder, Chiropractic Care, Diagnostic and Education Services, Hospital Outpatient Care, Mental Illness, Newborn Initial Care, Office Visits, Severe Mental Illness, Outpatient Surgery Center and Outpatient Therapies Out-of-Network: The first \$70 for Routine Mammograms

Blue Cross and Blue Shield of Montana (BCBSMT) Provider Network

In-Network Providers – In-Network providers accept the BCBSMT allowable fee, in addition to the deductible, coinsurance and copayment, as payment in full for covered services. In-Network providers submit claims for the member and BCBSMT pays In-Network providers directly. The member will not be billed amounts over the deductible, coinsurance and copayment.

Subject to applicable laws and regulations, if an In-Network provider is not available to provide medically necessary covered services, the Member may obtain the covered services from an Out-of-Network provider at the In-Network benefit level; however, the Out-of-Network provider may balance bill the Member the difference between the allowable fee and their charge, in addition to any deductible, coinsurance and copayment.

Out-of-Network Providers - Nonparticipating Providers have not contracted with BCBSMT to provide services at negotiated rates, and out of pocket expenses can be significantly higher. These providers are under no obligation to submit claims for the member and may bill the member the difference between the allowable fee and their charge, in addition to any deductible, coinsurance and copayment.

Emergency Services - Services provided in a Hospital emergency department (emergency room) for an emergency medical condition which is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn fetus. These services pay as In-Network, even if provided Out-of-Network. An Out-of-Network provider may bill the difference between the allowable fee and their charge, in addition to any deductible, coinsurance and copayment.

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 <http://provider.bcbs.com> or call 1-800-810 BLUE (2583).

The Appeals section in the Group Contract and Member Guide contains information regarding utilization review procedures, including procedures for obtaining review of adverse determinations, and the Member's rights with respect to those procedures.

Deductible, coinsurance and copayment 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 - BLUE DIMENSIONS

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 Including Mammograms and Well-Child 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 one electric), certain contraceptives and certain tobacco cessation products. Deductible, coinsurance and copayment 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	\$100 copayment for accidental injury and medical emergency. Deductible and coinsurance do not apply.		
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.		
Chiropractic and Acupuncture Services	Chiropractic: 10 visit maximum per benefit period. Acupuncture: 12 visit maximum per benefit period.		
Home Health Care	Up to 180 visits per benefit period.		
Hospice	Inpatient and outpatient care, home care, skilled nursing, and counseling. Deductible and coinsurance do not apply. Paid at 100% of the allowable fee.		
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.		
Substance Use Disorder	Processed under regular medical benefits.		
Mental Illness	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 (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 is available. This amount will not apply to the Out of Pocket Amount.)	The prescription drug copayments below are listed in the following order: generic / preferred brand name / non-preferred brand name Payment for Prescription Drugs purchased at a nonparticipating pharmacy will be reduced by 50% in addition to the nonparticipating Network coinsurance. This 50% benefit reduction does not apply to the Out of Pocket Amount.		
	Value Participating Pharmacy	Participating Pharmacy	Nonparticipating Pharmacy
Deductible:	\$150 deductible per Family Member then:		
Retail: 30-day supply	\$10 / \$40 / 60% up to a maximum of \$250	\$15 / \$50 / 60% up to a maximum of \$250	\$15 / \$50 / 60% up to a maximum of \$250
Retail: 90-day supply	Only available from a Value Participating Pharmacy \$30 / \$120 / 60% up to a maximum of \$600		
Mail Order: 90-day supply	Only available from a Mail Order Pharmacy approved by the Plan: \$20 / \$80 / 60% up to a maximum of \$400		
Specialty Medications: (30-day supply)	\$100 generic and preferred named brand / \$200 non-preferred name brand		

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.

Coinsurance: The percentage of the allowable fee payable by the Member for covered medical expenses. This plan has an In-Network coinsurance and a separate Out-of-Network coinsurance.

Copayment: The specific dollar amount payable by the Member for covered expenses.

Out of Pocket Amount: The total amount of deductible, coinsurance and copayments 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 prescription drugs does not apply to the out of pocket individual/family amount.

Rating Factors and Trend: The following rating factors are used: income and claims experience for the prior 12 months for the product being rated, the benefit difference for deductible, coinsurance and copayment for specific products in a category, projected claims, income and enrollment for the next 12-month rating period, projected expenses for the next rating period, and/or age of the applicant or subscriber, industry, and risk characteristics. The trend of premium increases during the preceding five years is: 2015 – 11%, 2016 – 10%, 2017 – 8.5%, 2018 – 6%, 2019 – 1.9%.

Your estimated premium will be _____.

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, clinic or hospital exceeds \$500.

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