SCHEDULE OF BENEFITS

Blue Preferred Gold PPO 007

Group Name:	BIG SKY COUNTY WATER & SEWER DIST 363
Group Number:	X01679
Effective Date:	June 1, 2016
Annual and Lifetime Plan Maximum:	None
Benefit Period:	Calendar Year

The Benefits are subject to the Benefit Period unless otherwise specified.

	In-Network	Out-of-Network
Deductible:		
Individual	$1,000	$2,000
Family	$2,000	$4,000
The In-Network and Out-of-Network Deductibles are separate amounts and one does not accumulate to the other.		
Copayments and Coinsurance do not accumulate to the Deductible.		
Coinsurance:	20%	40%
Copayments:		
Primary Care Provider (PCP)	$30	No Copayment; Deductible and Coinsurance Apply
Specialist	$60	No Copayment; Deductible and Coinsurance Apply
Urgent Care	$75	No Copayment; Deductible and Coinsurance Apply
Out of Pocket Amount:		
Individual	$3,000	$6,000
Family	$6,000	$12,000
The In-Network and Out-of-Network Out of Pocket Amounts are separate amounts and one does not accumulate to the other. Charges in excess of the Allowable Fee do not accumulate to help meet the Out of Pocket Amount.		

Some Benefits may have payment limitations. Refer to the specific Benefit in this Schedule of Benefits for additional information. In addition:

- For Emergency Services provided by an Out-of-Network Provider, Benefits will be provided as if such services were provided by an In-Network provider.
- Out-of-Network providers may bill the Member the difference between the Allowable Fee and the provider's charge, in addition to any Deductible, Copayment or Coinsurance even if Preauthorization is obtained for the service or treatment is provided for Emergency Services.

Term of Member Guide:	Monthly

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Accident		
Professional Provider Services	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services	20%	40%
Acupuncture	20%	40%
Maximum Per Benefit Period – 12 Visits		
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Ambulance	20%	20%
Autism Spectrum Disorders		
Services, except medications/prescription drugs and Applied Behavior Analysis (ABA) services that are described in the Benefit section entitled Autism Spectrum Disorders are covered under medical Benefits.		
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Medications/prescription drugs are covered under the Prescription Drug Program.		
ABA services are only covered for Members under 19 years of age	20%	40%
Birthing Centers	20%	40%
Chemical Dependency Treatment		
Professional Provider Services	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services	20%	40%
Chiropractic Services	20%	40%
Maximum Benefit Per Benefit Period for Chiropractic Manipulations – 10 Visits		
Convalescent Home Services	20%	40%
Maximum Per Benefit Period – 60 Days		
Diabetic Education Benefit		
The Deductible, Coinsurance and/or Copayment do not apply to the payment of the first $250. After the payment of $250, Deductible, Coinsurance and/or Copayment will apply.		
First $250	Deductible, Copayment and Coinsurance Do Not Apply	
After the first $250 in payment	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Diagnostic Services		
Diagnostic Imaging Services		
Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET Scan)		
Professional Provider Services	20%	40%
Facility Services	20%	40%
All Other Covered Diagnostic Services		
Professional Provider Services	20%	40%
Facility Services	20%	40%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Durable Medical Equipment		
Rental (up to Purchase Price), Purchase and Repair and Replacement of Durable Medical Equipment	20%	40%
Education Services		
Professional Provider Services	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services	20%	40%
Emergency Room Care	20%	20%
Home Health Care	20%	40%
Maximum Per Benefit Period – 180 Visits		
Hospice Care	Deductible, Copayment and Coinsurance Do Not Apply	
Hospital		
Professional Services (when the Professional Provider is employed by the Hospital)		
Outpatient	20%	40%
Inpatient	20%	40%
Facility Services		
Outpatient	20%	40%
Inpatient	20%	40%
Mammograms		
Routine	Deductible, Copayment and Coinsurance Do Not Apply	40%*
Medical	Deductible, Copayment and Coinsurance Do Not Apply	40%
*Deductible and Coinsurance Do Not Apply to the payment of the first $70 for Routine mammograms provided by an Out-of-Network provider.		
Maternity Services		
Professional Provider Services	20%	40%
(Refer to the section of the Schedule of Benefits entitled Office Visits. However, the Office Visit Copayment only applies to the initial visit. Subsequent visits are included in the charges for labor and delivery.)		
Facility Services	20%	40%
Medical Supplies	20%	40%
Mental Illness		
Professional Provider Services	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services	20%	40%
Newborn Initial Care		
Professional Provider Services	20%	40%
Facility Services	20%	40%
The Deductible applies after the first 5 days of initial care.		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION **Deductible applies to all services unless noted otherwise.**	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Office Visit		
Primary Care Provider (PCP) The Copayment applies to the office visit and covered services provided during the office visit, except surgery, Physical Therapy Speech Therapy, Occupational Therapy, Chiropractic Manipulation, Diagnostic Imaging, Laboratory Services and X-rays.	$30*, No Deductible	40%
Specialist The Copayment applies to the office visit and covered services provided during the office visit, except surgery, Physical Therapy Speech Therapy, Occupational Therapy, Chiropractic Manipulation, Diagnostic Imaging, Laboratory Services and X-rays. *Copayment does not apply to Preventive Health Care services. Refer to the section entitled Preventive Health Care.	$60*, No Deductible	40%
Orthopedic Devices/Orthotic Devices	20%	40%
Other Facility Services – Inpatient and Outpatient	20%	40%
Pediatric Dental Care (For Members under 19 years of age) Deductible and Coinsurance do not apply to fluoride treatments which are a Benefit for Members under age 19.	30%	30%
Pediatric Orthodontic Services Coverage limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria (e.g., severe, dysfunctional malocclusion) established by The Plan.	30%	30%
Pediatric Vision Care (For Members under 19 years of age)		
Routine Exam Maximum Per Benefit Period – 1 Exam	Deductible, Copayment and Coinsurance Do Not Apply	
Frames and Lenses Maximum Per Benefit Period – 1 Pair of Glasses or 2 Boxes of Contact Lenses	20%	40%
Physician Medical Services (Other than the Office Visit)	20%	40%
Prescription Drug Program Refer to the last page of this Schedule of Benefits.		
Preventive Health Care		
Routine Services	Deductible, Copayment and Coinsurance Do Not Apply	40%
Prostheses Benefit		
Rental (up to Purchase Price), Purchase and Repair and Replacement of Prosthetics	20%	40%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Rehabilitation Therapy		
Professional Services		
Outpatient	20%	40%
Inpatient	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services		
Outpatient	20%	40%
Inpatient	20%	40%
Severe Mental Illness		
Professional Provider Services	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services	20%	40%
Surgery Center Services - Outpatient		
Professional Provider Services	20%	40%
Facility Services	20%	40%
Therapies – Outpatient		
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy		
Professional Provider Services	20%	40%
Facility Services	20%	40%
Transplants		
Professional Services		
Outpatient	20%	40%
Inpatient	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services		
Outpatient	20%	40%
Inpatient	20%	40%
Urgent Care *Copayment does not apply to Preventive Health Care services. Refer to the section entitled Preventive Health Care.	$75*, No Deductible	40%
Well-Child Care Services	Deductible, Copayment and Coinsurance Do Not Apply	40%, No Deductible

PRESCRIPTION DRUG INFORMATION	DEDUCTIBLE	COPAYMENT/ COINSURANCE
Prescription Drug Program (The Prescription Drug Program utilizes a Drug List.) Copayments do not apply to certain contraceptive products. Refer to the Preventive Health Care Benefit. Copayments also do not apply to smoking cessation products and over-the-counter aids/medications, for two 90-day treatment regimens.		
Deductible	Does Not Apply	
Retail Value Participating Pharmacy Prescriptions Copayments for a **30-day supply** are:		
Preferred Generic:		No Copayment
Non-Preferred Generic:		$10
Preferred Brand-Name:		$50
Non-Preferred Brand-Name:		$100
Retail Participating Pharmacy Prescriptions Copayments for a **30-day supply** are:		
Preferred Generic:		$5
Non-Preferred Generic:		$15
Preferred Brand-Name:		$60
Non-Preferred Brand-Name:		$110
Retail Non-Participating Pharmacy Prescriptions Copayments for a **30-day supply** are:		
Preferred Generic:		$5
Non-Preferred Generic:		$15
Preferred Brand-Name:		$60
Non-Preferred Brand-Name:		$110
Payment for Prescription Drug Products purchased at a Non-Participating Pharmacy will be reduced by 50%, in addition to any Copayment.		
Mail Service Maintenance Prescriptions Copayments for a **90-day supply** are:		
Preferred Generic:		No Copayment
Non-Preferred Generic:		$30
Preferred Brand-Name:		$150
Non-Preferred Brand-Name:		$300
Retail Value Participating Pharmacy Prescriptions Copayments for a **90-day supply** are is:		
Preferred Generic:		No Copayment
Non-Preferred Generic:		$30
Preferred Brand-Name:		$150
Non-Preferred Brand-Name:		$300
Specialty Pharmaceuticals (**30-day supply** only)		$150*
***Specialty Pharmaceuticals, when purchased at a Non-Participating Specialty Pharmacy, are not covered.**		
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.		
Any Copayment amounts paid for prescription drugs do not apply to the Deductible and the 50% benefit reduction for prescription drugs purchased at a Non-Participating Pharmacy does not apply to the Out-of-Pocket maximum.		