SCHEDULE OF BENEFITS

MEDICAL PLAN

Traditional Plans-Allegiance • 1-877-778-8600 • Pre-certification 1-800-342-6510
www.abpmtpa.com • *See Plan Description for prior authorization requirements.*

Blue Cross/Blue Shield of MT Managed Care Plan • 1-800-820-1674 or 447-8747
www.bluecrossmontana.com • *See Plan Description for prior authorization requirements.*

New West Managed Care Plan • 1-800-290-3657 or 457-2200
www.newwesthealth.com • *See Plan Description for prior authorization requirements.*

Peak Managed Care Plan • 1-866-368-7325 • Pre-certification/prior auth. 1-866-275-7646
www.healthinfonetmt.com • *See Plan Description for prior authorization requirements.*

Life time maximum benefit- $2,000,000 all plans.

TRADITIONAL
Administered by

MEDICAL PLAN COSTS YOU PAY:	**Premium Plan**
Annual Deductible* *(Applies to all services, unless otherwise noted or a copayment is indicated)*	*$400/Member* *$800/Family*
Coinsurance Percentages*	
General (Including facilities that are neither preferred or nonpreferred)	25%
Preferred Facility Services *(See page 30 for a list of preferred facilities)*	20%
Nonpreferred Facility Services *(See page 30 for a list of non-preferred facilities)*	35%
Annual Coinsurance Maximums *(Maximum coinsurance paid in the benefit year; excludes deductibles and copayments)*	Average of $1,250/Member (20%-35% of $5,000 in allowable fees) Average of $2,500/Family (20%-35% of $10,000 in allowable fees)
Copayment* (on outpatient visits) *You pay deductible, coinsurance, and copayment on allowable fees only (See Glossary page 45.)	NA
MEDICAL PLAN SERVICE	Coinsurance is same as Basic Plan
Hospital Services *(Inpatient facility charges)* *(Pre-certification of hospitalization is strongly recommended.)*	
Room Charges	
Ancillary Services	
Surgical Services *(See Plan Description for surgeries requiring prior authorization)*	
Hospital and Surgi-Center	
Outpatient Services *(See Plan Description for surgeries requiring prior authorization)*	
Physician/Professional Provider Services (not listed elsewhere)	
Office Visit	
Inpatient Physician Services *(See Plan Description for surgeries requiring prior authorization)*	
Lab/Ancillary/Miscellaneous Charges	
Second Surgical Opinion	

BENEFIT YEAR 2005-2006

MEDICAL RATES

Monthly Premiums	Premium ($400 deductible)	Basic ($575 deductible)	BCBSMT Managed Care	Peak Managed Care	New West Managed Care
Employee	$469	$458	$422	$422	$414
Employee & spouse \ A.D.	$594	$572	$535	$535	$520
Employee & children	$579	$561	$521	$521	$506
Employee & family	$660	$617	$594	$594	$579

PLANS

Allegiance

MANAGED CARE BENEFIT PLANS

BCBSMT – Administered by Blue Cross/Blue Shield of MT
NEW WEST – Administered by New West Health Plan
PEAK – Administered by Peak Health Plan/Allegiance

Basic Plan	In-Network Benefits	Out-of-Network Benefits
$575 / Member $1,150 / Family	$300 / Member $600 / Family (deductible does not apply to out patient sevices / visits with dollar copays)	Separate $500 / Member Separate $1,000 / Family
25%	25%	35%
20%		
35%		
Average of $2,500 / Member (20%-35% of $10,000 in allowable fees) Average of $5,000 / Family (20%-35% of $20,000 in allowable fees)	$2,000 / Member $4,000 / Family	Separate $2,000 / Member Separate $4,000 / Family
NA (See exceptions below)	$15 / visit (See exceptions below)	NA (See exceptions below)
Coinsurance	**Coinsurance**	**Coinsurance**
20% – 35% (depending on whether a preferred, non preferred or other facility see above)	25%	35%
20% – 35%	25%	35%
20% – 35%	25%	35%
20% – 35%	25%	35%
25%	$15 / visit (some routine lab & diagnostic included)	35%
25%	25%	35%
25%	25%	35%
0% (Plan pays 100% of allowable fee, no deductible)	$15 / visit	35%

SCHEDULE OF BENEFITS

MEDICAL PLAN COSTS YOU PAY:

Emergency Services

Ambulance Services for Medical Emergency

Emergency Room
Facility Charges

Professional Charges

Urgent Care Services

Facility/professional Charges

Lab & Diagnostic Charges

Maternity Services

Hospital Charges

Physician Charges (delivery and inpatient)

Prenatal Office Visits

Routine Newborn Care

Inpatient Hospital Charges

Preventive Services

Adult Exams and Tests (age 19+)
Mammogram, gyn exam and pap, proctoscopic, sigmoidoscopic and colonoscopic exams, limited routine lab work, such as PSA tests, and basic blood panel.
For managed care plans only, bone density tests.

Immunizations and Pneumonia and Flu shots

Child Checkups through age 2

Mental Illness Services

Inpatient Services
(Pre-certification is strongly recommended)
Max: One inpatient day may be exchanged for two partial hospitalization days.

Outpatient Services

Chemical Dependency

Inpatient Services
(Pre-certification is strongly recommended.)

Outpatient Services

* Dollar benefit max for inpatient services of $4,000/year, $8,000/lifetime
** Dollar benefit max for combined inpatient/outpatient services of $6,000/year; $12,000/lifetime; $2,000/year after max is met.

BENEFIT YEAR 2005-2006

TRADITIONAL PLANS	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
25%	$100 copay	$100 copay
$25 / visit (waived if immediately admitted to hospital) deductible and coinsurance apply	$75 / visit (waived if inpatient hospital or patient surgery coinsurance applies)	$75 / visit (same waiver as In-Network)
25%	25%	25%
25%	$25 / visit	$25 / visit
25%	25%	35%
20% – 35%	25%	35%
25%	25%	35%
25%	$50 global copay for: routine labs & office visits	35%
25 – 35%	25%	35%
0% (no deductible) up to max on: gyno exam & PAP **Max:** $75 / yr. mammogram up to allowable prostrate exam **Max:** $50 / yr. 25% (deductible applies) on: routine lab (PSA, blood panel), proctoscopy, sigmoidoscopy, and colonoscopy **Max:** one / year starting at age 50	$15 / visit for periodic physicals (including PSA gyn exam & PAP, basic blood panel and other routine limited lab work) $0 copay for mammogram 25% for bone density scan, sigmoidoscopy, colonosocopy, and proctoscopy	35%
0% (no deductible) up to max **Max:** $250 / yr. up to age 19 $75 / yr. age 19 + $50 / yr. on pneumonia and flu shots	$15 / visit 25% (no deductible) without office visit	$35%
0% (no deductible) up to max **Max:** $500 first 2 years of life	$15 / visit **Max:** Academy of Pediatrics Definitions (through age 18)	35%
20% – 35% **Max:** 30 days / yr. (No max for severe conditions)	25% **Max:** 21 days / yr. (No max for severe conditions)	35% **Max:** 21 days / yr. (No max for severe conditions)
20% – 35% **Max:** 40 visits / yr. (No max for severe conditions)	25% **Max:** 30 days / yr. (No max for severe conditions)	35% **Max:** 30 days / yr. (No max for severe conditions)
25% – 35% **Max:** Dollar limit*	25%	35%
25% **Max:** $1,000 / year	$15 / visit **Max:** Dollar Limit**	35% **Max:** Dollar Limit**

SCHEDULE OF BENEFITS

MEDICAL PLAN COSTS YOU PAY:

Rehabilitative Services

Physical, Occupational, Cardiac, Respiratory, Pulmonary and Speech Therapy

Inpatient Services

(Pre-certification is strongly recommended.)

Outpatient Services

Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

(Prior authorization required for managed care plans)

Extended Care Services

Home Health Care

[Physician ordered / prior authorization is strongly recommended (or required) by most plans. See Plan Descriptions]

Hospice

Skilled Nursing

[Prior authorization is strongly recommended (or required) by most plans. See Plan Descriptions]

Miscellaneous Services

Allergy Shots

Dietary / Nutritional Counseling

(When medically necessary and physician ordered)

Durable Medical Equipment, Prosthetic Appliances and Orthotics

(Prior authorization required for most managed care plans for amounts > $500)
(Prior authorization required for traditional plans for amounts > $1,000)

PKU Supplies

(Includes treatment and medical foods)

Education Programs on Disease Processes (when ordered by a physician)

(Prior authorization required for managed care plans and strongly recommended for traditional plans)

Obesity Management

(Prior authorization required by all plans)

Infertility Treatment (biological infertility only)

(Prior authorization required for all plans with coverage)

Organ Transplants

(Prior authorization required for managed care plans and strongly recommended for traditional plans)

Transplant Services

BENEFIT YEAR 2005-2006

TRADITIONAL PLANS	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
20% – 35% **Max:** 30 days / yr. Respiratory & Pulmonary rehab. not subject to max	25% **Max:** 60 days / yr	35% **Max:** 60 days / yr
25% (20% – 35% if hospital based)	$15 / visit **Max:** 30 visits / yr	35% **Max:** 30 visits / yr
Member pays charges over $25 / visit	Not covered	Not Covered
Member pays charges over $25 / visit	Not covered	Not Covered
Member pays charges over $25 / visit **Max:** 15 visits / yr. in any combination for alternative health care	$15 / visit **Max:** 20 visits / yr	Not Covered
25% **Max:** 90 day / yr.; 180 / lifetime	$15 / visit **Max:** 30 visits / yr	35% **Max:** 30 visits / yr
25% (20% – 35% if hospital-based)	25% **Max:** 6 months	35% **Max:** 6 months
25% (20% – 35% if hospital-based) **Max:** 180 days / confinement	25% **Max:** 30 days / confinement	35% **Max:** 30 days / confinement
25% (no deductible)	$15 / visit 25% (no deductible) without office visit	35%
Not covered (except through campus wellness program)	$15 / visit	35%
25% **Max:** $100 for foot orthotics (per foot) / yr.	$25 / visit (Not applied to coinsurance max) **Max:** $100 for foot orthotics (per foot) / yr.	35% (Not applied to coinsurance max) **Max:** $100 for foot orthotics (per foot) / yr.
25%	0% (no deductible) Plan pays 100% of allowable fees for services required under State mandate	35%
0% (no deductible) up to max (Plan pays 100% of allowable fees) **Max:** $250 / yr.	0% (no deductible) up to max (Plan pays 100% of allowable fees) **Max:** $250 / yr.	Not Covered
Not covered (Except bariatric surgery and through campus) Wellness Program) **Max:** $25,000 on surgery / lifetime	25% Non-surgical treatment plan only	Not Covered
Not covered	25% **Max:** 3 artificial inseminations / lifetime	Not Covered
25% See choices Group Benefit Plan for benefit description / limitations	25% **Max:** $500,000 lifetime maximum with $5,000 of the maximum available for travel to and from the facility	Not Covered