

**This material is presented as general information only. The content is not to be accepted as a substitute for the provisions of the master policies.**

## Comparison of Benefits

All percentages are “of allowable fee” unless otherwise indicated

COVERED SERVICES	HEALTH FIRST PPO	ADVANTAGE PPO	CMM HSA PPO \$2,400	CMM HSA PPO \$5,000	HDHP \$5,000 PPO Limited Lifetime Plan	BIG SKY SELECT <i>(See the Participating Providers section for an explanation of Levels A, B, and C)</i>			BLUE SAVER
<b>LIFETIME MAXIMUM BENEFIT</b>	\$5,000,000 per member				\$800,000 Lifetime maximum \$200,000 Annual maximum	\$5,000,000 per member			
<b>DEDUCTIBLE</b>	\$1,000 Individual \$2,000 Family	\$1,500 Individual \$3,000 Family	\$2,400 Individual \$4,800 Family	\$5,000 Individual \$10,000 Family	\$5,000 Individual \$10,000 Family	<b>Level A</b> No deductible	<b>Level B</b> \$500 Individual \$1,000 Family	<b>Level C</b> \$1,000 Individual \$2,000 Family	\$4,000 Individual \$8,000 Family
<b>COINSURANCE</b>	70/30 Until maximum member liability is met.	60/40 Until maximum member liability is met.	100%. After deductible is met, no coinsurance	100%. After deductible is met, no coinsurance	100%. After deductible is met, no coinsurance	<b>Level A</b> \$20 office copayment	<b>Level B</b> 50% copayment	<b>Level C</b> 50% copayment	100%
<b>MAXIMUM MEMBER LIABILITY (MML)</b>	\$2,000 Individual \$4,000 Family (deductible plus coinsurance)	\$3,000 Individual \$6,000 Family (deductible plus coinsurance)	\$2,400 Individual \$4,800 Family	\$5,000 Individual \$4,800 Family	\$5,000 Individual \$10,000 Family	\$1,500 Individual \$3,000 Family (does not include <b>Level B and C deductibles</b> )			\$4,000 Individual \$8,000 Family
<b>PROFESSIONAL SERVICES/ OFFICE VISITS</b>	Diagnostic x-ray and lab, surgery, emergency medical services, chemotherapy, and radiation therapy.								
	<b>Deductible waived for Participating Professional Providers</b> Paid at 70%.	<b>Deductible waived for Participating Professional Providers.</b> Paid at 60%.	Deductible applies.	Deductible applies.	Deductible applies.	<b>Level A</b> \$20 office visit copayment.	<b>Level B</b> Deductible applies. Paid at 50%.	<b>Level C</b> Deductible applies. Paid at 50%.	Primary care benefit covering the first \$750 of primary care services received from a BCBSMT Participating Provider paid at 100%.

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<b>HOSPITAL SERVICES</b> <b>Inpatient</b>	Room and board, special care units, and ancillary charges.							
<b>Outpatient</b>	Diagnostic x-ray and lab, surgery, emergency medical services, chemotherapy, and radiation therapy.							
	Transplants are covered up to \$500,000 lifetime maximum, including \$10,000 per transplant for ambulance or commercial transportation to transplant site and \$25,000 per transplant for organ procurement.							
	Deductible applies. Paid at 70%.	Deductible applies. Paid at 60%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%.	Benefits available on <b>Level B or C</b> only.	<b>Level B</b> Deductible applies. Paid at 50%. <b>Level C</b> Deductible applies. Paid at 50%.	Deductible applies, then paid at 100%.
<b>CONVALESCENT CARE</b>	Skilled nursing facility extended care facility/units, transitional care units. 60 days per benefit period.							
	Deductible applies. Paid at 70%.	Deductible applies. Paid at 60%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%.	Benefits available on <b>Level B or C</b> only.	<b>Level B</b> Deductible applies. Paid at 50%. <b>Level C</b> Deductible applies. Paid at 50%.	Deductible applies, then paid at 100%.
<b>ACCIDENT-RELATED SERVICES</b>								
	Paid same as illness.	Paid same as illness.	No special accident benefit.	No special accident benefit.	No special accident benefit.	\$100 Emergency room copayment. \$40 Urgent care clinic copayment.	Primary care benefit may apply.	
<b>AMBULANCE</b>								
	Deductible applies. Paid at 70%.	Deductible applies. Paid at 60%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%.	<b>Level B</b> benefits.	Deductible applies.	

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<b>DURABLE MEDICAL EQUIPMENT PROSTHETICS</b>	Deductible applies. Paid at 70%. Replacements paid at 50%. Prior authorization recommended if over \$500. Maximum member liability does not apply.	Deductible applies. Paid at 60%. Replacements paid at 50%. Prior authorization recommended if over \$500. Maximum member liability does not apply.	Deductible applies. Paid at 100%. Maximum member liability applies.	Deductible applies. Paid at 100%. Maximum member liability applies.	Deductible applies, then paid at 100%	<b>Level B</b> benefits.	Deductible applies. Paid at 100%. Maximum member liability applies.
<b>MEDICAL SUPPLIES ORTHOPEDIC DEVICES BLOOD TRANSFUSION SERVICES</b>	Deductible applies. Paid at 70%.	Deductible applies. Paid at 60%.	Deductible applies. Paid at 100%.	Deductible applies. Paid at 100%.	Deductible applies, then paid at 100%	<b>Level B</b> benefits.	Deductible applies. Paid at 100%.
<b>HOME HEALTH CARE</b>	Paid at 50% up to 180 visits per benefit period.						
	Any amounts you pay do not apply toward the Maximum Member Liability provision. No deductible.	Any amounts you pay do not apply toward the Maximum Member Liability provision. No deductible.	Deductible applies. Paid at 50%. Maximum member liability applies.	Deductible applies. Paid at 50%. Maximum member liability applies.	Deductible applies, then paid at 50%	Any amounts you pay do not apply toward the Maximum Member Liability provision. No deductible.	Deductible applies. Paid at 50%. Maximum member liability applies.
<b>HOSPICE</b>	Paid at 100%.	Paid at 100%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%	Paid at 100%.	Deductible applies, then paid at 100%.

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<b>MAJOR ORGAN TRANSPLANT COVERAGE</b>	Paid under the hospital and professional services benefit. \$500,000 lifetime maximum.								
<b>REHABILITATION THERAPY</b>	Multidisciplinary therapy including, but not limited to, physical therapy and speech therapy. The maximum member liability provision does not apply.								
	Deductible applies except for Participating Professional Provider services. Paid at 70% up to the lifetime maximum of \$100,000.	Deductible applies except for Participating Professional Provider services. Paid at 60% up to the lifetime maximum of \$100,000.	Deductible applies. If preauthorized as medically necessary, paid as any other illness up to the \$100,000 lifetime maximum.	Deductible applies. If preauthorized as medically necessary, paid as any other illness up to the \$100,000 lifetime maximum.	Deductible applies. If preauthorized as medically necessary, paid as any other illness up to the \$100,000 lifetime maximum.	Paid like any other services up to the \$100,000 lifetime maximum. Prior authorization recommended.	Deductible applies. If preauthorized as medically necessary, paid as any other illness up to the \$100,000 lifetime maximum.		
<b>SPEECH THERAPY, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND CARDIAC REHABILITATION</b>	There is a \$2,000 maximum per benefit period for outpatient professional and facility services.								
	Deductible waived for Participating Professional Providers. Paid at 70%.	Deductible waived for Participating Professional Providers. Paid at 60%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%	<b>Level A</b> 100% after a \$20 copayment for professional provider services. Covered services received in a facility will be covered on <b>Level B or C.</b>	<b>Level B</b> Deductible and copayment apply.	<b>Level C</b> Deductible and copayment apply.	Deductible applies, then paid at 100%.

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<b>CHIROPRACTIC SERVICES</b>	\$600 maximum per benefit period. Does not include x-ray maximum. \$100 maximum per benefit year for x-rays.								
	Deductible waived for Participating Professional Provider services. Paid at 70%.	Deductible waived for participating professional provider services. Paid at 60%	Deductible applies. Paid at 100%.	Deductible applies, then paid at 100%.	Deductible applies, then paid at 100%.	<b>Level A</b> Paid at 100% after a \$20 copayment.	<b>Level B</b> Deductible applies. Paid at 50%.	<b>Level C</b> Deductible applies. Paid at 50%.	Benefits are not available on this plan.
<b>MENTAL ILLNESS</b>	Mental illness, including severe mental illness is processed under regular medical benefits. However, the following maximums apply to Autism, Asperger’s Disorder and Pervasive Development Disorder for physical therapy, speech therapy and applied behavioral analysis (ABA) services: \$50,000 per year for a child 8 years of age or younger; \$20,000 per year for a child 9 years of age through 18 years of age Partial hospitalization is covered on a two-for-one basis – two days of partial hospitalization equals one day of inpatient care.								
<b>Outpatient Services</b>	Paid at 70%.  Deductible waived for Participating Professional Provider services. Deductible applies to facility and nonparticipating professional providers services.	Paid at 60%.  Deductible waived for Participating Professional Provider services. Deductible applies to facility and nonparticipating providers services.	Deductible applies. Paid at 100%	Deductible applies. Paid at 100%	Deductible applies. Paid at 100%.	<b>Level A</b> \$20 copayment for Professional provider services. Benefits for services received in a facility available on <b>Level B or C.</b>	<b>Level B</b> Deductible and copayment apply.	<b>Level C</b> Deductible and copayment apply.	Deductible applies. Paid at 100%.
<b>Inpatient Services</b>	Paid at 70%.	Paid at 60%.	Deductible applies. Paid at 100%	Deductible applies. Paid at 100%	Deductible applies. Paid at 100%	Benefits available on <b>Level B or C only.</b>	Deductible and copayment apply.	Deductible and copayment apply.	Deductible applies. Paid at 100%.

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<b>CHEMICAL DEPENDENCY</b>	Paid as any other illness								
<b>Inpatient Services</b>	Deductible waived for Participating Professional Provider services. Deductible applies to facility and nonparticipating professional providers services. Paid at 70%.	Deductible waived for Participating Professional Provider services. Deductible applies to facility and nonparticipating professional providers services. Paid at 60%.	Deductible applies. Paid at 100%	Deductible applies. Paid at 100%	Deductible applies. Paid at 100%	Benefits available on <b>Level B or C</b> only.	Deductible and copayment apply.	Deductible and copayment apply.	Deductible applies. Paid at 100%.
<b>WELL-CHILD CARE</b>									
	Deductible waived. Paid at 70% for children through 7 years of age.	Deductible waived. Paid at 60% for children through 7 years of age.	No deductible. Paid at 100% for children through 7 years of age.	No deductible. Paid at 100% for children through 7 years of age.	No deductible. Paid at 100% for children through 7 years of age.	Member pays \$20 per visit on <b>Level A.</b>			No deductible. Paid at 100% for children through 7 years of age.
<b>MAMMOGRAM</b>	Paid at 100% of allowable charge <ul style="list-style-type: none"> <li>• One baseline mammogram for women ages 35 through 39.</li> <li>• One mammogram every two years for women ages 40 through 49, or more frequently as recommended by a physician.</li> </ul> One mammogram every year for women age 50 or older.								
<b>OUTPATIENT DIABETIC EDUCATION</b>	Paid at 100% up to \$250/year; deductible and coinsurance apply after the first \$250 is paid								
<b>COLONOSCOPIES</b>									
	Paid at 100% of allowable charge. No age limits. Office call and hemocults continue to process under standard preventive benefit.	Paid at 100% of allowable charge. No age limits. Office call and hemocults continue to process under standard preventive benefit. Colonoscopies with a medical diagnosis are subject to deductible.		Pays the same as the other HSA eligible options.		Facility charges paid at 100% of allowed charge regardless of diagnosis and status of the provider; deductible and copayment waived. No age limits. Provider charges paid at 100% of allowed fee, copayment waived.			Paid at 100% of allowable charge.

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<b>OTHER PREVENTIVE HEALTH CARE</b>	No deductible for smoking cessation aids. Paid at 100%.  \$150 preventive health benefits. No deductible or copayment. Paid at 100%.	No deductible for smoking cessation aids. Paid at 100%.  \$150 preventive health benefits. No deductible or copayment. Paid at 100%.	Smoking cessation aids are covered after the deductible is met.  \$500 preventive health benefits.	Smoking cessation aids are covered after the deductible is met.  \$500 preventive health benefits.	Smoking cessation aids are covered after the deductible is met.  \$500 preventive health benefits. No deductible or copayment. Paid at 100%.	All routine physical exams, including gynecological exams, hearing exams, vaccinations and immunizations, preventive care, and hearing screenings, are paid at 100% after a \$20 copayment on <b>Level A</b> .	Primary care benefit covering the first \$750 of primary care services received from a BCBSMT Participating Provider. Paid at 100%.
<b>PREVENTIVE DENTAL</b>	Paid at 100% of billed charges up to \$100 maximum per year for exams and/or cleanings. Network restrictions do not apply. Processes under the medical plan benefits.						
<b>PRESCRIPTION DRUGS</b>	Oral contraceptives are covered. Mandatory generic replacement – member pays the difference between generic and brand-name drug if the generic is available but is not purchased, plus the applicable copayment.						
	<p><b>\$200 deductible, separate from the medical deductibles, then:</b></p> <p><b>Retail Pharmacy purchase:</b> Copayment for 34-day supply: \$10 Generic \$15 Formulary brand-name \$25 Nonformulary brand-name</p> <p><b>Mail Service Program:</b> Copayment for 90-day supply: \$20 Generic \$30 Formulary brand-name \$50 Nonformulary brand-name</p>	<p>Deductible applies, then paid at 100%.</p> <p>Preferred pricing discount available when you use your ID card at Participating Pharmacies when you purchase prescription drugs. File the claim with BCBSMT for reimbursement.</p>	<p>Deductible applies, then paid at 100%.</p> <p>Preferred pricing discount available when you use your ID card at Participating Pharmacies when you purchase prescription drugs. File the claim with BCBSMT for reimbursement.</p>	<p>Deductible applies, then paid at 100%.</p> <p>Preferred pricing discount available when you use your ID card at Participating Pharmacies when you purchase prescription drugs. File the claim with BCBSMT for reimbursement.</p>	<p><b>\$200 deductible, separate from the medical deductibles, then:</b></p> <p><b>Retail Pharmacy purchase:</b> Copayment for 34-day supply: \$10 Generic \$15 Formulary brand-name \$25 Nonformulary brand-name</p> <p><b>Mail Service Program</b> Copayment for 90-day supply: \$20 Generic \$30 Formulary brand-name \$50 Nonformulary brand-name</p>	<p>Deductible applies. Paid at 100%.</p>	

