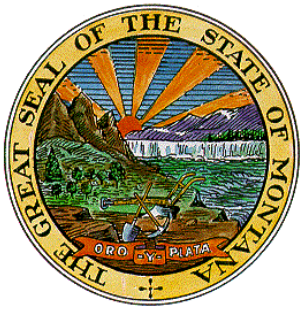
2003



Medical Plan
Benefits Summary
&
Insurance Cost Comparison

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN

NON-MEDICARE MEDICAL RATES

Monthly Premiums	Traditional	Basic	Peak	New West	Blue Choice
Retiree	$331	$308	$318	$317	$335
Retiree & spouse	$498	$455	$483	$486	$509
Retiree & children	$452	$415	$441	$443	$463
Retiree & family	$526	$480	$509	$512	$537
Retiree & Medicare spouse	$449	$411	$437	$440	$460
Retiree & Medicare spouse and child	$471	$430	$457	$461	$482

MEDICARE MEDICAL RATES

Monthly Premiums	Traditional	Medicare Coordinated	Peak	Blue Choice	New West
Medicare retiree	$205	$177	$200	$209	$200
Medicare retiree & spouse	$403	$349	$394	$414	$397
Medicare retiree & children	$343	$298	$338	$354	$341
Medicare retiree & family	$425	$367	$414	$436	$418
Medicare retiree & Medicare spouse	$354	$307	$348	$365	$352
Medicare retiree & Medicare spouse & family	$390	$336	$382	$401	$385

MEDICAL PLAN COSTS

	Administered by BCBS and APS TRADITIONAL/ MEDICARE COORDINATED
Annual Deductible* *(Applies to all services, unless otherwise noted)*	$435/Member $1,305/Family
Coinsurance Percentages	
General	25%
Preferred Facility Services *(See page 36 for a list of preferred facilities)*	20%
Nonpreferred Facility Services *(See page 36 for a list of non-preferred facilities)*	35%
Annual Out-of-Pocket Maximums* *(Maximum coinsurance paid in the year; excludes deductibles and copayments)*	Average of $1,500/Member *(20% - 35% of $6,000 in allowable charges)* Average of $3,000/Family *(20% - 35% of $12,000 in allowable charges)*

*You pay deductible and coinsurance on allowable charges only (see Glossary on page 4).

MEDICAL PLAN SERVICES

	Coinsurance:
Hospital Services *(Inpatient services must be certified. Pre-certification is strongly recommended.)*	20% - 35%
Room Charges	20% - 35%
Ancillary Services	20% - 35%
Surgical Services	20% - 35%
Outpatient Services	20% - 35%

BENEFIT YEAR 2003

DENTAL & VISION RATES (both medicare & non-medicare)

Monthly Premiums	Dental	Vision
Retiree	$28.60	$7.85
Retiree & spouse	$34.60	$12.40
Retiree & children	$41.60	$12.65
Retiree & family	$46.60	$20.40

BASIC	MANAGED CARE BENEFIT PLANS BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan PEAK - Administered by Peak Health Plan	
Administered by BCBS and APS	**In-Network Benefits**	**Out-of-Network Benefits**
$1,305/Member $2,610/Family	$300/Member $600/Family	Separate $500/Member Separate $1,000/Family
25% 20% 35%	25%	35%
Average of $2,500/Member *(20% - 35% of $10,000 in allowable charges)* Average of $5,000/Family *(20% - 35% of $20,000 in allowable charges)*	$2,000/Member $4,000/Family	Separate $2,000/Member Separate $4,000/Family
Coinsurance/Copayment:	**Coinsurance/Copayment:**	**Coinsurance:**
20% - 35%	25%	35%
20% - 25%	25%	35%
20% - 25%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS	TRADITIONAL/ MEDICARE COORDINATED
Physician Services	
Office Visits	25% (no deductible for two office visits)
Inpatient Physician Services	25%
Lab/Ancillary/Miscellaneous Charges	25%
Emergency Services	
Ambulance Services for Medical Emergency	25%
Emergency Room Hospital Charges	20% - 35%
Professional Charges	25%
Urgent Care Facility Services - Hospital Based Hospital Charges	20% - 35%
Professional Charges	25%
Urgent Care Facility Services - Free Standing Facility Services	25%
Professional Charges	25%
Maternity Services	
Hospital Charges	20% - 35%
Physician Charges	25%
Prenatal Office Visits	25%
Routine Newborn Care Inpatient Hospital Charges	20% - 35% (no deductible)
Physician and Lab Charges	0% (no coinsurance, no deductible)
Preventive Services	
Adult Exams and Tests Mammogram, gyno exam and pap, proctoscopic and colonoscopic exams, PSA tests, bone density tests	25% (no deductible) **Max**: 2 bone density tests/lifetime **Max**: $130 for colonoscopy & sigmoidoscopy
Adult Immunizations for Pneumonia and Flu	Not covered
Well-Child Checkups and Immunizations	25% (no deductible) 0% (no deductible for County Health Department) *(through age 5)*
Mental Health Services	
Mental Health Care Inpatient Services *(Inpatient services must be certified. Pre-certification is strongly recommended.)* **Max**: One inpatient day may be exchanged for two partial hospital days.	20% - 35% 21 days *(No max for severe conditions)*
Outpatient Services With required referral or EAP counselor referral	25% **Max**: 40 visits *(No max for severe conditions)*
With NO required referral or EAP counselor referral	50% **Max**: 20 visits *(No max for severe conditions)*

BENEFIT YEAR 2003

BASIC	IN-NETWORK	OUT-OF-NETWORK
$15/visit (no deductible)	$15/visit (some lab & diagnostic included)	35%
25%	25%	35%
25%	25%	35%
25%	$100 copay	Covered under In-Network Benefit
20% - 35%	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	Covered under In-Network Benefit
25%	25%	25%
20% - 35%	$25/visit	$25/visit
25%	25%	35%
25%	$25/visit	$25/visit
25%	25%	35%
20% - 35%	25%	35%
25%	25%	35%
25%	$50 global copay for all prenatal care	35%
20% - 35% (no deductible)	25%	35%
0% (no coinsurance, no deductible)	25%	35%
25% (no deductible) **Max**: 2 bone density tests/lifetime **Max**: $130 for colonoscopy & sigmoidoscopy	$15/visit (periodic physicals covered, including PSA, PAP, basic blood panel, and limited lab work) $0 co-pay for mammogram 25% for bone density scan, sigmoidoscopy, colonoscopy, proctoscopy	35%
Not covered	$15 with office visit (Allergy shots 25%, with no deductible in-network)	35%
25% (no deductible) 0% (no deductible for County Health Department) *(through age 5)*	$15/visit **Max**: Academy of Pediatrics Definitions *(through age 18)*	35%
20% - 35% 21 days *(No max for severe conditions)*	25% 21 days *(No max for severe conditions)*	35%
25% **Max**: 40 visits *(No max for severe conditions)*	$15/visit **Max**: 30 visits *(No max for severe conditions)*	35%
50% **Max**: 20 visits *(No max for severe conditions)*	$15/visit **Max**: 30 visits *(No max for severe conditions)*	35%

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS	TRADITIONAL/ MEDICARE COORDINATED
Chemical Dependency	
Inpatient Services* *(Inpatient services must be certified. Pre-certification is strongly recommended.)*	20% - 35%
Outpatient Services* With required referral or EAP counselor referral	25% **Max**: 40 visits and Dollar Limit*
With NO required referral or EAP counselor referral	50% **Max**: 20 visits and Dollar Limit*
*Dollar Limit Max for all Chemical Dependency Services: Combined inpatient/outpatient max of $6,000/year; $12,000/lifetime; $2,000/year thereafter.	
Rehabilitative Services	
Physical, Occupational, and Speech Therapy Inpatient Services *(Inpatient services must be certified. Pre-certification is strongly recommended.)*	20% - 35% **Max**: 60 days
Outpatient Services – Hospital	20% - 35% **Max**: $2,000/year for all outpatient ($10,000/year for prior auth. conditions)
Outpatient Services – Non-Hospital	25% **Max**: $2,000/year for all outpatient ($10,000/year for prior auth. conditions)
Alternative Health Care Services	
Acupuncture	25% (plus charges over $30/visit)
Naturopathic	25% (plus charges over $30/visit)
Chiropractic	25% (plus charges over $30/visit) **Max**: 25 visits in any combination for alternative health care
Extended Care Services	
Home Health Care *(Physician ordered/prior authorization recommended)*	25% **Max**: 70 days
Hospice	25% (20% - 35% if hospital-based) **Max**: 6 months
Skilled Nursing	25% (20% - 35% if hospital-based) **Max**: 70 days
Miscellaneous Services	
Dietary/Nutritional Counseling *(When medically necessary and physician ordered)*	20% - 35% **Max**: $250
Durable Medical Equipment, Appliances, and Orthotics *(Prior authorization required for amounts >$500)*	25% **Max**: $100 for foot orthotics (per foot)
PKU Supplies	25%
Transportation *(Limited to reasonable one-way expenses for services not available in MT)*	25%
Organ Transplants *(Must be certified. Pre-certification is strongly recommended.)* Transplant Services **Lifetime Maximums:**	25% • Liver: $200,000 • Heart: $120,000 • Lung: $160,000 • Heart/Lung: $160,000 • Bone Marrow: $160,000 • Pancreas: $68,000 • Cornea/Kidney: No maximum

BENEFIT YEAR 2003

BASIC	IN-NETWORK	OUT-OF-NETWORK
20% - 35%	25%	35%
25% **Max**: 40 visits and Dollar Limit*	$15/visit **Max**: Dollar Limit*	35%
50% **Max**: 20 visits and Dollar Limit*	$15/visit **Max**: Dollar Limit*	35%
20% - 35% **Max**: 60 days	25% **Max**: 60 days	35% **Max**: 60 days
20% - 35% **Max**: $2,000/year for all outpatient ($10,000/year for prior-auth. conditions)	$15/visit **Max**: 30 visits	35% **Max**: 30 visits
25% **Max**: $2,000/year for all outpatient ($10,000/year for prior-auth. conditions)	$15/visit **Max**: 30 visits	35%
25% (plus charges over $30/visit)	Not covered	Not covered
25% (plus charges over $30/visit)	Not covered	Not covered
25% (plus charges over $30/visit) **Max**: 25 visits in any combination for alternative health care	$15/visit **Max**: 20 visits for chiropractic subject to required referral	Not covered
25% **Max**: 70 days	$15/visit **Max**: 30 visits	35% **Max**: 30 visits
25% (20% - 35% if hospital-based) **Max**: 6 months	25% **Max**: 6 months	35% **Max**: 6 months
25% (20% - 35% if hospital-based) **Max**: 70 days	25% **Max**: 30 days instead of hospitalization	35% **Max**: 30 days instead of hospitalization
20% - 35% **Max**: $250	$15/visit **Max**: no limit	35%
25% **Max**: $100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) **Max**: $100 for foot orthotics (per foot)	35%
25%	0% (Plan pays for 100% for services required under State mandate.)	35%
25%	Ambulance service & organ transplant only	Not covered
25% • Liver: $200,000 • Heart: $120,000 • Lung: $160,000 • Heart/Lung: $160,000 • Bone Marrow: $160,000 • Pancreas: $68,000 • Cornea/Kidney: No maximum	25% $500,000 lifetime maximum with $5,000 of the maximum available for travel to and from the facility.	Not covered

MEDICAL INSURANCE COST COMPARISONS FOR RETIREES

The following medical insurance cost comparisons show how the Traditional Plan and Medicare-Coordinated Plan would process the same service, and what costs the retired plan member would be responsible for paying. Costs for deductible and coinsurance are cumulative within the example. The first line of each example shows the total costs. The next three lines show how that cost is divided between copays, costs applied to the deductible, and coinsurance costs. It does not include premium costs, which are outlined on page 7. This example assumes the services were for one member. This is simply an example and is not a guarantee that similar services will process identically.

Coinsurance percentages

Regular/Managed Care	25%
Preferred Hospital Services (Indemnity Plans)	20%
Nonpreferred Hospital Services (Indemnity Plans)	35%
Out-of-Network Managed Care	35%

Deductible levels

Traditional	$435/$1,305
Medicare Coordinated	$435/$1,305
Managed Care	$300/$600

MEDICARE RETIREES

Sample Services	Medicare Allowable Charge	Your Responsibility After Medicare pays	Traditional	Medicare Coordinated
Office visits 1 & 2 ($50 each)	**$100**	**$100**	**You pay ➡ $25**	**$25**
Copay costs				
Costs applied to deductible		$100 (applied)	$100 (applied)	$100 (applied)
Coinsurance costs			$25	$25
Specialist visit (i.e. cardiologist)	**$500**	**$100**	**You pay ➡ $0**	**$100**
Copay costs				
Costs applied to deductible			$335 (applied)	$335 (applied)
Coinsurance costs		$100		$100
X-Rays	**$100**	**$20**	**You pay ➡ $0**	**$20**
Copay costs				
Costs applied to deductible				
Coinsurance costs		$20	$0	$20
Preferred hospital inpatient	**$8,500**	**$792**	**You pay ➡ $0**	**$792**
Copay costs				
Costs applied to deductible				
Coinsurance costs		$792		$792
Nonpreferred hospital inpatient	**$8,500**	**$792**	**You pay ➡ $0**	**$792**
Copay costs				
Costs applied to deductible				
Coinsurance costs		$792		$792