



2011 Comparison of Benefits

All percentages are "of allowable fee" unless otherwise indicated

This summary of benefits is based on the official legal documents that establish the Contract. If there is any conflict between the information contained in this summary and the actual terms of the Contract as contained in the official legal documents, the legal documents will govern.

COVERED SERVICES	SECURITY	HEALTH SAVINGS ACCOUNT QUALIFIED PLAN 5000	HEALTH SAVINGS ACCOUNT QUALIFIED PLAN 2400	BIG SKY SELECT		
LIFETIME MAXIMUM BENEFITS	Unlimited					
DEDUCTIBLE				Level A \$0	Level B \$500 \$1,000	Level C \$1,000 \$2,000
Individual Family	\$1,500 \$3,000 The deductible is waived for the following services: Preventive Health Benefit <ul style="list-style-type: none"> • Doctor Office Visits • Chiropractic • Professional provider services • Routine newborn care • Rehabilitation therapy • Durable medical equipment (DME) and prosthetics • Outpatient care for mental illness • Outpatient chemical dependency • Well-child care • Home health care • Hospice • Outpatient diabetic education 	\$5,000 \$10,000 The deductible is waived for the following services: <ul style="list-style-type: none"> • Preventive Health Services • Well-child care • Outpatient diabetic education 	\$2,400 \$4,800 The deductible is waived for the following services: <ul style="list-style-type: none"> • Preventive Health Services • Well-child care • Outpatient diabetic education 		The deductible is waived on Levels B and C for the following services: <ul style="list-style-type: none"> • Preventive Health Services • DME and prosthetics • Home health • Hospice • Mammograms • Outpatient diabetic education • Routine newborn care • Well-child care 	



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COVERED SERVICES	SECURITY	HEALTH SAVINGS ACCOUNT QUALIFIED PLAN 5000	HEALTH SAVINGS ACCOUNT QUALIFIED PLAN 2400	BIG SKY SELECT		
				Level A	Level B	Level C
COPAYMENT	70/30 until out-of-pocket amount is met.	You pay 100% until your deductible is met. Then Plan pays 100%.	You pay 100% until your deductible is met. Then Plan pays 100%.	\$10 office copayment \$20 urgent care copayment \$100 emergency room copayment	60% coinsurance	60% coinsurance
OUT-OF-POCKET AMOUNT (OOP)	Deductible plus copayment.			Does not include Level B and C deductibles.		
Individual	\$1,500	\$5,000	\$2,400	\$1,500		
Family	\$3,000	\$10,000	\$4,800	\$3,000		



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PROFESSIONAL SERVICES/ OFFICE VISITS	Deductible waived for professional providers. Paid at 70%.	Paid at 100% after deductible.	Paid at 100% after deductible.	Level A \$10 office visit copayment.	Level B Deductible applies. Paid at 60%.	Level C Deductible applies. Paid at 60%.
HOSPITAL SERVICES Inpatient/Outpatient	Room and board, special care units, and ancillary charges; Plan notification for inpatient admissions is recommended. Diagnostic x-ray and lab, surgery, emergency medical services, chemotherapy, and radiation therapy.					
	Paid at 70% after deductible.	Paid at 100% after deductible.	Paid at 100% after deductible.	Benefits available on Levels B or C only. Deductible applies. Paid at 60%.		
CONVALESCENT CARE	Skilled nursing facility extended care facilities/units, and transitional care units 60 days per benefit period.					
	Paid at 70% after deductible.	Paid at 100% after deductible.	Paid at 100% after deductible.	Benefits available on Levels B or C only. Deductible applies. Paid at 60%.		
ACCIDENT-RELATED SERVICES	Paid at 70% after deductible.	Paid at 100% after deductible.	Paid at 100% after deductible.	Paid the same as any other illness. \$100 emergency room copayment. \$20 urgent care clinic copayment.		
AMBULANCE	Deductible applies. Paid at 70%.	Paid at 100% after deductible.	Paid at 100% after deductible.	Level B Deductible applies. Paid at 60%.		
DURABLE MEDICAL EQUIPMENT/ PROSTHETICS	Deductible applies. Paid at 70%. Replacements paid at 50%. OOP does not apply.	Paid at 100% after deductible.	Paid at 100% after deductible.	Deductible waived. Paid at 60%.		
MEDICAL SUPPLIES ORTHOPEDIC DEVICES BLOOD TRANSFUSION SERVICES	Deductible applies. Paid at 70%.	Paid at 100% after deductible.	Paid at 100% after deductible.	Level B benefits.		
HOME HEALTH CARE	180 visits per benefit period. The Out-of-Pocket Amount provision does not apply to this benefit.					
	No deductible. Paid at 50%.	Paid at 100% after deductible.	Paid at 100% after deductible.	Deductible waived. Paid at 60%.		
HOSPICE	No deductible. No copayment. Paid at 100%.	Paid at 100% after deductible.	Paid at 100% after deductible.	No deductible. No copayment. Paid at 100%.		
MAJOR ORGAN TRANSPLANT COVERAGE	Paid under hospital and professional services benefits.					



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COVERED SERVICES	SECURITY	HEALTH SAVINGS ACCOUNT QUALIFIED PLAN 5000	HEALTH SAVINGS ACCOUNT QUALIFIED PLAN 2400	BIG SKY SELECT		
REHABILITATION THERAPY	Rehabilitation therapy performed by a multidisciplinary team. The OOP does not apply to this benefit.					
SPEECH THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY CARDIAC REHABILITATION	Deductible applies except for professional provider services. Paid at 70%.	Paid at 100% after deductible.	Paid at 100% after deductible.	Deductible and copayment apply. Paid at 60%.		
	Deductible applies except for professional provider services. Paid at 70%.	Paid at 100% after deductible.	Paid at 100% after deductible.	Level A \$10 office visit copayment.	Level B Deductible and copayment apply.	Level C Deductible and copayment apply.
CHIROPRACTIC SERVICES	\$400 maximum per benefit period. \$100 maximum per benefit year for x-rays.					
	No deductible. Paid at 70%.	Paid at 100% after deductible.		Level A \$10 office visit copayment.	Level B Deductible and copayment apply.	Level C Deductible and copayment apply.
MENTAL ILLNESS						
Outpatient Services	No deductible. Paid at 70%.	Deductible applies. Paid at 100%.		Level A \$10 office visit copayment.	Level B Deductible and coinsurance apply.	Level C Deductible and coinsurance apply.
Inpatient Services	Deductible applies. Paid at 70%.	Deductible applies. Paid at 100%. Paid at 100% after deductible.		Not a benefit on Level A.	Deductible and coinsurance apply.	Deductible and coinsurance apply.



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CHEMICAL DEPENDENCY						
Outpatient Services	No deductible. Paid at 70%.	Paid at 100% after deductible.	Paid at 100% after deductible.	Level A Paid at 60%	Level B Deductible and coinsurance apply.	Level C Deductible and coinsurance apply.
Inpatient Services	Deductible applies. Paid at 70%.	Paid at 100% after deductible.	Paid at 100% after deductible.			
WELL-CHILD CARE	No deductible. Paid at 100%.					
MAMMOGRAMS	Paid at 100% of the actual charge.			Paid at 100% on Level A.		
COLONOSCOPIES	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.					
OUTPATIENT DIABETIC EDUCATION	\$250 maximum per benefit period.					
	No deductible. No copayment.	Deductible waived.		No deductible. No copayment.		
TEMPOROMANDIBULAR JOINT SYNDROME (TMJ)	No deductible for professional services. Deductible applies to splints, night guards, etc. Services paid at 70%.	Paid at 100% after deductible.		Insured pays \$10 per visit on Level A benefits.		



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PRESCRIPTION DRUGS	<p>\$200 individual/\$400 family deductible, separate from the medical deductible, then:</p> <p>Retail pharmacy purchase: Copayment for 34-day supply: \$10 generic \$20 formulary brand-name \$30 nonformulary brand-name</p> <p>Mail order service program: Copayment for 90-day supply: \$20 generic \$40 formulary brand-name \$60 nonformulary brand-name</p> <p>Mandatory generic provision applies. The insured pays the difference between generic and brand-name drug if the generic is available but is not purchased, plus the applicable copayment.</p>	Paid at 100% after deductible.		<p>\$200 individual/\$400 family deductible, separate from the medical deductible, then:</p> <p>Retail pharmacy purchase: Copayment for 34-day supply: \$10 generic \$20 formulary brand-name \$30 nonformulary brand-name</p> <p>Mail order service program: Copayment for 90-day supply: \$20 generic \$40 formulary brand-name \$60 nonformulary brand-name</p> <p>Mandatory generic provision applies. The insured pays the difference between generic and brand-name drug if the generic is available but is not purchased, plus the applicable copayment.</p>