BlueCross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

Preferred Blue® PPO

Summary of Benefits Northwest Nazarene University **Effective Date: 08/01/2008**		**Preferred Blue® PPO Large Group**	
Benefit Period* Deductible (Individual/Family)		$1,000/$2,000	
Coinsurance		You pay 20% of the allowed amount for covered services	You pay 40% of the allowed amount for covered services
Out-of-Pocket Limit (Does not include deductible, drugs, dental and vision, non-covered services and charges over the allowed amount.)		$3,000 In-Network	$6,000 Out-of-Network
Comprehensive Lifetime Benefit Limit (Per insured)		$1,000,000	
COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. Some services may require prior authorization.*	**In-Network deductible and/or coinsurance payment required before insurance pays?**	**In-Network**	**Out-of-Network**
		The amount you pay	
Allergy Injections	No	You pay a $5 copayment (*if this is the only service provided during the visit)*	You pay 40% of the allowed amount
Ambulance Transportation Services	Yes	You pay 20% of the allowed amount	
Chiropractic Care (Limited to $800 per insured, per benefit period.)	Yes		You pay 50% of the allowed amount
Dental Services Related to Injury (Covered only for the 12-month period immediately following the date of injury, providing your group's contract remains in effect during that 12-month period.)	Yes		You pay 40% of the allowed amount
Diabetes Self-Management Education Services (From approved providers only. Limited to $500 per insured, per benefit period.)	No	You pay a $20 copayment	Not covered, you pay 100% of the billed charges
Diagnostic Services (including diagnostic mammograms.)	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Durable Medical Equipment			
Emergency Services			
Home Health Skilled Nursing (Limited to $5,000 per insured, per benefit period.)			
Home Intravenous Therapy	Yes		Not covered, you pay 100% of the billed charges
Hospice Services ($10,000 lifetime benefit limit per insured. There are no benefits for services rendered by non-contracting hospice providers.)	No	You pay nothing	
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Inpatient Physical Rehabilitation ($150,000 lifetime benefit limit per insured. There are no benefits for services rendered by non-contracting facility providers.)	Yes		Not covered, you pay 100% of the billed charges
Maternity Services	Yes		You pay 40% of the allowed amount
Mental Health – **Inpatient** (Limited to 8 inpatient days per insured, per benefit period.) – **Outpatient** (Limited to 20 outpatient visits per insured, per benefit period.)	Yes	You pay 50% of the allowed amount	Not covered, you pay 100% of the billed charges
Orthotic Devices	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to $2,000 combined per insured, per benefit period.)	Yes	You pay 50% of the allowed amount	Not covered, you pay 100% of the billed charges

Physician Office Visit (Other services rendered during a physician office visit will be subject to deductible and coinsurance.)	No	You pay a $20 copayment	You pay 40% of the allowed amount
Post Mastectomy Reconstructive Surgery	Yes	You pay 20% of the allowed amount	
Prosthetic Appliances			
Skilled Nursing Facility (Limited to 30 days per insured, per benefit period.)			
Selected Therapy Services (Including chemotherapy, enterostomal therapy, growth hormone therapy, radiation, renal dialysis, respiratory therapy, and inpatient occupational therapy.)			
Surgical/Medical (Professional Services)			
Transplant Services			
Preventive Care Benefits (See policy for specifically listed services.)	Yes/No	You pay nothing for services specifically listed up to $500. For services in excess of $500, you pay deductible and coinsurance	
Immunizations (See policy for specifically listed immunizations.)	No	You pay nothing for listed immunizations	

PRESCRIPTION DRUG BENEFITS		
	In-Network **RETAIL** Copayment	**Out-of-Network** **RETAIL** Copayment
Generic Drugs	You pay $10 + 20% per prescription	You pay $10 +20% per prescription
Brand Name Drugs	You pay $30 + 20% per prescription	You pay $30 +20% per prescription
BCI Approved Mail Order Participating Pharmacy		
Generic Drugs	You pay $10 + 20% per prescription	
Brand Name Drugs	You pay $30 + 20% per prescription	

*The specified period of time during which charges for covered services must be incurred in order to accumulate toward annual benefit limits, deductible amounts and out-of-pocket limits.

This summary describes the general features of this program; it is not a contract.
All provisions of the Group Master Policy apply to this program.
Noncontracting providers may bill you for amounts over our maximum allowance.

SUMMARY OF GENERAL EXCLUSIONS AND LIMITATIONS

No benefits will be provided for services, supplies, drugs or other charges that are:

- Not medically necessary. If services requiring prior authorization by Blue Cross of Idaho are performed by a contracting provider and benefits are denied as not medically necessary, the cost of said services are not the financial responsibility of the insured. However, the insured could be financially responsible for services found to be not medically necessary when provided by a noncontracting provider.
- In excess of the maximum allowance.
- For hospital inpatient or outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an accidental injury or unless an attending physician certifies in writing that the insured has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the insured's health and life.
- Not prescribed by or upon the direction of a physician or other professional provider; or which are furnished by any individuals or facilities other than licensed general hospitals, physicians, and other providers.
- Investigational in nature.
- Provided for any condition, disease, illness or accidental injury to the extent that the insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal workers' compensation acts, or under employer liability acts, or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the insured claims such benefits or compensation, or recovers losses from a third party.
- Provided or paid for by any federal governmental entity except when payment under the policy is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or would be affected by the existence of coverage under the policy, or for which payment has been made under Medicare Part A and/or Medicare Part B, or would have been made if an insured had applied for such payment except when payment under the policy is expressly required by federal law.
- Provided for any condition, accidental injury, disease or illness suffered as a result of any act of war or any war, declared or undeclared.
- Furnished by a provider who is related to the insured by blood or marriage and who ordinarily dwells in the insured's household.
- Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- For surgery intended mainly to improve appearance or for complications arising from surgery intended mainly to improve appearance, except for:
    - Reconstructive surgery necessary to treat an accidental injury, infection, or other disease of the involved part; or
    - Reconstructive surgery to correct congenital anomalies in an insured who is a dependent child.
    - Benefits for reconstructive surgery to correct an accidental injury are available even though the accident occurred while the insured was covered under a prior insurer's coverage, if there is no lapse between the prior coverage and coverage under the policy.
- Rendered prior to the insured's effective date, or during an inpatient admission commencing prior to the insured's effective date, except as specified in the general provisions section of the policy.
- For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance), or convenience items or services even if prescribed by a physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools and therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, massage, or music.
- For telephone consultations; and all computer or internet communications; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a physician or other professional provider.
- For inpatient admissions that are primarily for diagnostic services or therapy services; or for inpatient admissions when the insured is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change, or for treatment not requiring continuous bed care.
- For inpatient or outpatient custodial care; or for inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a covered service in the policy.
- For any cosmetic foot care, including but not limited to, treatment of corns, calluses, and toenails (except for surgical care of ingrown or diseased toenails).
- Related to dentistry or dental treatment, even if related to a medical condition; or orthoptics, eyeglasses or contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as a covered service in the policy.
- For hearing aids or examinations for the prescription or fitting of hearing aids.
- For any treatment of either gender leading to or in connection with transsexual surgery, gender transformation, sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.
- Made by a licensed general hospital for the insured's failure to vacate a room on or before the licensed general hospital's established discharge hour.
- Not directly related to the care and treatment of an actual condition, illness, disease or accidental injury.
- Furnished by a facility that is primarily a place for treatment of the aged or that is primarily a nursing home, a convalescent home, or a rest home.
- For acute care, rehabilitative care, or diagnostic testing or evaluation of mental or nervous conditions, alcoholism, substance abuse or addiction, or for pain rehabilitation, except as specified as a covered service in the policy.
- Incurred by an eligible dependent child for care or treatment of any condition arising from or related to pregnancy, childbirth, delivery, or an involuntary complication of pregnancy, unless specifically provided as a covered service in the policy.
- For any of the following, even if it is a result of a congenital anomaly or a developmental problem and even if it is medically necessary—for appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a covered service in the policy; for orthognathic surgery, including services and supplies to augment or reduce the upper or lower jaw; for implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies; or for alveolectomy or alveoloplasty when related to tooth extraction.
- For weight control or treatment of obesity or morbid obesity, even if medically necessary, including but not limited to surgery for obesity. For reversals or revisions of surgery for obesity, except when required to correct an immediately life-endangering condition.
- For use of operating, cast, examination, or treatment rooms or for equipment located in a contracting or noncontracting provider's office or facility, except for emergency room facility charges in a licensed general hospital, unless specified as a covered service in the policy.
- For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.
- Treatment for infertility and fertilization procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance an insured's reproductive ability.
- For transplant services and artificial organs, except as specified as a covered service under the policy.
- For acupuncture.
- For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, laser-in-situ keratomileusis (lasik), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if medically necessary, unless specified as a covered service in a vision benefits section of the policy, if any. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.
- For hospice home care, except as specified as a covered service in the policy.
- For pastoral, spiritual, bereavement, family, and/or marriage counseling.
- For homemaker and housekeeping services or home-delivered meals.
- For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation.
- For treatment or other health care of any insured in connection with an illness, disease, accidental injury or other condition which would otherwise entitle the insured to covered services under the policy, if and to the extent those benefits are payable to or due the insured under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar policy of insurance, contract, or underwriting plan.
- In the event Blue Cross of Idaho (BCI) for any reason makes payment for or otherwise provides benefits excluded by the above provisions, it shall succeed to the rights of payment or reimbursement of the compensated provider, the insured, and the insured's heirs and personal representative against all insurers, underwriters, self-insurers, or other such obligors contractually liable or obliged to the insured, or his or her estate for such services, supplies, drugs or other charges so provided by BCI in connection with such illness, disease, accidental injury or other condition.
- Any services or supplies for which an insured would have no legal obligation to pay in the absence of coverage under the policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.
- For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual illness, disease or accidental injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physicals; or a screening examination, unless specified as a covered service under the policy.
- For immunizations except as provided as a covered service in the policy.
- For breast reduction surgery or surgery for gynecomastia.
- For nutritional supplements, nutritional replacements, nutritional formulas, prescription vitamins and minerals.
- For an elective abortion, surgical or medical, or complications from an elective abortion, except to preserve the life of the female upon whom the abortion is performed, unless benefits for an elective abortion are specifically provided by a separate endorsement to the policy.
- For alterations or modifications to a home or vehicle.
- For special clothing, including shoes (unless permanently attached to a brace).
- Provided to a person enrolled as an eligible dependent, but who no longer qualifies as an eligible dependent due to a change in eligibility status that occurred after enrollment.
- Provided outside the United States, which if had been provided in the United States, would not be a covered service under the policy.
- Furnished by a provider or caregiver that is not listed as a covered provider, including but not limited to, naturopaths.
- For outpatient pulmonary and/or cardiac rehabilitation.
- For complications arising from the acceptance or utilization of noncovered services.
- For the use of hypnosis, as anesthesia or other treatment, except as specified as a covered service.
- For dental implants, appliances, and/or prosthetics, and/or treatment related to orthodontia, even when medically necessary, unless specified as a covered service in the policy.
- For arch supports, orthopedic shoes, and other foot devices.
- Benefits for contraceptives, unless specified as a covered service in the policy.
- For wigs and cranial molding helmets.
- For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.
- For the purchase of therapy or service dogs/animals and the cost of training/maintaining said animals.