Northwest Nazarene University
PPO
Effective Date: August 1, 2007

Quick View
$1,000 Deductible
$2,000 Combined Family Deductible
$4,000 In-network Out-of-pocket Limit (Includes Deductible)
Benefit Period: January 1 through December 31

Form #3-346 (1-2007)

PREFERRED BLUE MASTER GROUP POLICY BENEFITS OUTLINE

This Benefits Outline describes the benefits of this Policy in general terms. It is important to read the Policy in full for specific and detailed information that includes additional exclusions and limitations on benefits. Your manager of employee benefits should be able to help if you have questions.

Throughout this Policy, Blue Cross of Idaho may be referred to as BCI. For Covered Services under the terms of this Policy, Maximum Allowance is the amount established by BCI as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section.

To locate a Contracting Provider in your area, please visit our Web site at www.bcidaho.com. The Provider Directory is located on the left side of the page. Click on the "Search" button directly under "Provider Directory" and you will be taken to our searchable Directory. You may also call our Customer Services Department at 208-331-7347 or 800-627-1188 for assistance in locating a Provider.

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ELIGIBILITY AND ENROLLMENT

To qualify as an Eligible Employee under this Policy, a person must be and remain a full-time employee, sole proprietor, or partner of the Group who regularly works at least 20 hours per week and is paid on a regular, periodic basis through the Group's payroll system.

(see the Policy for additional Eligibility and Enrollment provisions)

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PROBATIONARY PERIOD

The Group will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Policy.

Note: In order to receive maximum benefits, some covered services require Emergency Admission Notification, NonEmergency Preadmission Notification, and/or Prior Authorization. Please review the Inpatient Admission notification Section, Prior Authorization Section and Attachment A of this Benefits Outline for specific details.

Insureds should check with BCI to determine if the treatment or service being considered requires Prior Authorization. All Inpatient Admissions and Emergency Admissions require Inpatient Notification Review or Emergency Admission Review, as appropriate.

If an Insured chooses a Noncontracting or a nonparticipating Provider, the Insured may be responsible for any charges that exceed BCI's Maximum Allowance.

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COMPREHENSIVE MAJOR MEDICAL BENEFITS		
Deductibles: Individual	Insured pays first $1,000 of eligible expenses per Benefit Period, except for specifically listed In-Network Wellness/Preventive Care Services, Physician Office Visits, and preventive screening mammogram services	
Family	Insureds pay a combination of $2,000 of eligible expenses for all Insureds under same Family Coverage per Benefit Period, except for specifically listed In-Network Wellness/Preventive Care Services, Physician Office Visits, and preventive screening mammogram services *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible)*	
	In-Network	**Out-of-Network**
Out-of-pocket Limit (see Policy for services that do not apply to the limit)	Insured pays $4,000 of eligible expenses per Benefit Period (includes Deductible and Coinsurance) *When the Out-of-pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for In-Network Covered Services that require a Copayment, dental care, vision care, and Prescription Drug Covered Services.*	Insured pays $7,000 of eligible expenses per Benefit Period (includes Deductible and Coinsurance) *When the Out-of-pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for dental care, vision care, and Prescription Drug Covered Services.*
Comprehensive Lifetime Benefit Limit	BCI pays up to $1,000,000 on behalf of an Insured for all combined Covered Services. Payments applied toward specific Lifetime Benefit Limits also apply toward the all-inclusive Comprehensive Lifetime Benefit Limit.	

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SERVICES BCI COVERS	AMOUNT OF PAYMENT	
	In-Network	**Out-of-Network**
Allergy Injections	Insured pays $5 Copayment per visit if this is the only service provided during the visit	BCI pays 60% of Maximum Allowance after Deductible

	In-Network	Out-of-Network
Ambulance Transportation Service	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
Chiropractic Care Services	**In-Network**	**Out-of-Network**
	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 50% of Maximum Allowance after Deductible
	(up to a combined total of $800 per Insured, per Benefit Period)	
Dental Services Related to Accidental Injury	**In-Network**	**Out-of-Network**
	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
Diabetes Self-Management Education Services (Only for Providers approved by BCI)	**In-Network**	**Out-of-Network**
	Insured pays $20 Copayment per visit (BCI pays up to $500 per Insured, per Benefit Period)	No benefits
Diagnostic Services	**In-Network**	**Out-of-Network**
	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
Durable Medical Equipment	**In-Network**	**Out-of-Network**
	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
Emergency Services *(see the Policy for services and conditions that affect continuing benefit payments)*	**In-Network**	**Out-of-Network**
	BCI pays 80% of Maximum Allowance after Deductible (Contracting and Noncontracting Facility Providers and Facility-based Professional Providers Only)	BCI pays 60% of Maximum Allowance after Deductible
Home Health Skilled Nursing Care Services	**In-Network**	**Out-of-Network**
	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	(up to a combined total of $5,000 per Insured, per Benefit Period)	

	In-Network	Out-of-Network
Hospice Services	BCI pays 100% of Maximum Allowance (Deductible does not apply) (Lifetime Benefit Limit is $10,000 per Insured)	No benefits
	In-Network	**Out-of-Network**
Hospital Services	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Inpatient Physical Rehabilitation Care	BCI pays 80% of Maximum Allowance after Deductible (Lifetime Benefit Limit is $150,000 per Insured)	No benefits
	In-Network	**Out-of-Network**
Maternity Services and/or **Involuntary Complications of Pregnancy**	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Orthotic Devices	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Outpatient Rehabilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy	BCI pays 50% of Maximum Allowance after Deductible (up to combined total of $2,000 per Insured, per Benefit Period)	No benefits

	In-Network	Out-of-Network
Physician Office Visits	Insured pays $20 Copayment per visit (any additional services, such as treatment and diagnosis of Mental/Nervous Conditions, or lab, x-ray, and other Diagnostic Services are subject to Deductible and Coinsurance)	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Post-Mastectomy Reconstructive Surgery	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Preventive Mammogram Screening Services	Insured pays $20 Copayment per visit	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Prosthetic Appliances	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Psychiatric Inpatient Services *(Inpatient Facility Services)*	BCI pays 50% of Maximum Allowance after Deductible (up to 8 days per Insured, per Benefit Period)	No benefits
	In-Network	**Out-of-Network**
Psychiatric Outpatient Services *(Outpatient Facility services and Inpatient and Outpatient services of Covered Professional Providers)*	BCI pays 50% of Maximum Allowance after Deductible (up to 20 visits per Insured, per Benefit Period)	No benefits
	In-Network	**Out-of-Network**
Skilled Nursing Facility	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	up to a combined total of 30 days per Insured, per Benefit Period	

	In-Network	Out-of-Network
Selected Therapy Services	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Surgical/Medical (Professional Services)	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Transplant Services	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Wellness/Preventive Care Services For specifically listed services *Well-Baby and Well-Child Care—routine or scheduled well-baby and well-child examinations, including Rubella and PKU tests.* *Adult Examinations—annual physical examinations, including pap tests, fecal occult blood tests, PSA tests, and cholesterol panels.*	Insured pays $20 Copayment per visit	No benefits
	In-Network	**Out-of-Network**
For services not specifically listed	BCI pays 80% of Maximum Allowance after Deductible	No benefits
	In-Network	**Out-of-Network**
Immunizations *Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rubella, Tetanus, Varicella (Chicken Pox) and routine immunizations included in the State of Idaho Vaccine for Children Program, as amended or revised* (Other immunizations may be covered at the discretion of BCI when Medically Necessary. No benefits are provided for travel vaccines.)	Immunizations require no Copayment	No benefits

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SUPPLEMENTAL ACCIDENT BENEFITS	
For Covered Providers and Services	BCI pays up to $500 per insured, per Benefit Period (after which Deductibles and Coinsurance apply)

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

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VISION CARE BENEFITS (VSP)	
For Covered Providers and Services	
Copayment	Insured pays $0 per eye exam and/or $25 per Frame and Lenses or Medically Necessary Contact Lenses.
Service Frequency Limitations	Insured may receive one (1) eye exam and/or one (1) pair of Lenses and/or one (1) Frame or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) every twelve (12) months.
Elective—includes basic eye exam and an allowance of $120 in place of benefits for Prescribed Lenses and Frames	
Payment for Services Rendered	
Participating VSP Doctor	BCI pays 100% of Maximum Allowance after Copayment

Nonparticipating VSP Doctor	Plan III
Professional Fees	
Eye Exam	$45
Materials—lenses per pair	
Single Vision	$48
Bifocals, up to	$65
Trifocals, up to	$90
Frame, up to	$45
Contact Lenses— per pair	
(evaluation, materials, and fittings only)	$120
Medically Necessary, up to	$250

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DENTAL CARE BENEFITS (PPO)

For Covered Providers and Services		
Benefit Limit	$1,000 per Insured, per Benefit Period	
Deductible: Individual	Insured pays $25 per Benefit Period (does not apply to In-network Preventive Covered Services)	
Family	The Benefit Period Family Deductible is satisfied after three (3) Insureds of the same family have met their Individual Deductible (No Insured may contribute more than the Individual Deductible amount toward the Family Deductible)	
DENTAL CARE BENEFITS (PPO)	**There is no Deductible for In-Network Preventive Services**	
	In-Network	**Out-of-Network**
Preventive Covered Services	100% of Maximum Allowance	80% of Maximum Allowance after Deductible
Basic Dental Services	80% of Maximum Allowance after Deductible	70% of Maximum Allowance after Deductible
Major Covered Services	50% of Maximum Allowance after Deductible	40% of Maximum Allowance after Deductible

Attachment A:
NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE
EFFECTIVE: January 1, 2007

NOTICE: ***The Medical Necessity of Covered Services listed below should be determined to be eligible for benefits under the terms of this Policy. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in this decision to deny must be resolved by use of the Blue Cross of Idaho appeal process.***

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured.

The Insured is financially responsible for Non-Medically Necessary services provided by a Noncontracting Provider.

Blue Cross of Idaho will respond to a request for Prior Authorization received from either the Provider or the Insured within two (2) business days of the receipt of the medical information necessary to make a determination. For additional information, please check with your Provider, call Customer Service at the telephone number listed on the back of the Insured's Identification Card or check the BCI Web site at www.bcidaho.com.

Surgical Services – Inpatient or Outpatient

- Organ and tissue transplants
- Gallbladder surgery
- Arthroscopic surgery of the knee, hip, shoulder, wrist, or jaw
- Nasal and sinus procedures
- Eyelid surgery
- Spinal surgery
- Hysterectomy
- Gastric reflux procedures
- Plastic and reconstructive surgery
- Surgery for snoring or sleep problems
- Invasive treatment of lower extremity veins (including but not limited to varicose veins)
- Advanced imaging services (not applicable for inpatient services):
    - Magnetic Resonance Imaging (MRI)
    - Magnetic Resonance Angiography (MRA)
    - Computed Tomography Scans (CT Scan)
    - Positron Emission Tomography (PET)

Other Services

- Inpatient stays that originate from an Outpatient service
- Diabetes self management education
- Home intravenous therapy
- Non-emergent ambulance
- Certain prescription drugs (including drugs that cost five hundred dollars ($500) or more)
- Restorative dental services following accidental injury to sound natural teeth
- Hospice services
- Growth hormone therapy
- Genetic testing services
- Home health skilled nursing services

The following services require Prior Authorization when the expected charges exceed three hundred dollars ($300):

- Rental or purchase of Durable Medical Equipment
- Prosthetic Appliances
- Orthotic Devices

Form No. 3-103 (rev. 01/07)