



Blue ValueSM

Summary of Benefits for Kootenai County Effective 11/01/2009		Blue Value SM	
Benefit Period* Deductible (Member/Family) (No Member may contribute more than the Individual Deductible amount toward the Family Deductible.)		\$400 Individual/\$800 Family	
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: amounts that exceed the maximum allowance, services that require a copayment, amounts that exceed benefit limits, dental care services, vision care services, prescription drug services, or non-covered services or supplies)		\$2,000 Individual/\$4,000 Family	
Comprehensive Lifetime Benefit Limit (Per member)		\$1,000,000	
COVERED SERVICES <i>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.</i>	Deductible and/or coinsurance payment required before insurance pays?	In-Network	Out-of-Network*
		The amount you pay	
Ambulance Transportation Services	Yes		You pay 40% of the allowed amount
Chiropractic Care	Chiropractic Care (Limited to \$500 combined per member, per benefit period.)	Yes	You pay 20% of the allowed amount
Mental Health and Substance Abuse (Inpatient and Outpatient Facility and Professional Services)	Yes		You pay 40% 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 \$400 per member, per benefit period. \$1,200 combined lifetime benefit limit per member)	Yes	You pay 20% of the allowed amount	Not covered, you pay 100% of the billed charges
Diagnostic Services (includes diagnostic Mammograms.)	Yes		You pay 40% of the allowed amount
Durable Medical Equipment, Prosthetic Appliances, and Orthotic Devices			
Emergency Services – Facility Services (Copayment waived if admitted.)	Yes	Member pays \$250 copayment for hospital Outpatient emergency room visit after which you pay 20% of the allowed amount	Member pays \$250 copayment for hospital Outpatient emergency room visit after which you pay 40% of the allowed amount
Home Health Skilled Nursing (Limited to \$5,000 combined per member, per benefit period.)	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Home Intravenous Therapy			
Hospice Services (\$5,000 combined lifetime benefit limit per member and maximum of 6 months from initial date care is provided.)			
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)			

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		The amount you pay	
Human Growth Hormone (Limited to \$25,000 per member, per benefit period.)	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Inpatient Physical Rehabilitation (Limited to \$15,000 combined max per member, per benefit period.)	Yes		
Maternity Services (Physician Services including prenatal, delivery, and postnatal care.)	Yes		
Outpatient Rehabilitation Therapy Services (Includes physical, speech, occupational, respiratory, and cardiac rehab therapies. Limited to \$1,000 per member, per benefit period for each therapy service. Limit is combined in and out-of-network)			
Physician Office Visit			
Post Mastectomy Reconstructive Surgery			
Prescription Contraceptive Major Medical Coverage	No	You pay \$25 Diaphragms You pay \$20 Injectables You pay \$100 Norplant	
Skilled Nursing Facility (Limited to 30 days combined per member, per benefit period)	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Surgical/Medical (Professional Services)			
Transplant Services			
Preventive Care Benefits <i>For specifically listed services: Annual adult physical examinations; routine or scheduled well-baby and well-child examinations; Bone Density; Chemistry Panels; Cholesterol Screening; Colonoscopy, Sigmoidoscopy, Fecal Occult Blood Test; Complete Blood Count (CBC); Diabetes Screening; Pap Test; PKU; PSA Test; Rubella; Screening EKG; Thyroid Stimulating Hormone (TSH); Transmittable Diseases Screening (Chlamydia, Gonorrhea, HIV, Syphilis, Tuberculosis (TB)); Urinalysis (UA); Screening examinations for school or sports physicals and preventive screening mammograms.</i>	Yes/No	You pay \$15 copayment per visit for services specifically listed up to \$300. For services in excess of \$300, you pay deductible and coinsurance	You pay 20% of the allowed amount
Immunizations (See contract for specifically listed immunizations.)	No	You pay \$5 copayment per injection	

*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 Contract apply to this program.
Noncontracting providers may bill you for amounts over the maximum allowance.



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Prescription Benefits		
Retail (34 day supply) Mail Order (90 day supply with one copay)	Generic	You pay 25% to a max of \$25 copayment
	Formulary Brand Name	You pay 25% to a max of \$100 copayment
	Non-Formulary Brand Name	You pay 50% to a max of \$200 copayment