SuperBlue Plus 2008

$1,500 Deductible

III. SUMMARY OF BENEFITS INSERT

IMPORTANT: PLEASE READ THE SUMMARY OF BENEFITS SECTION OF YOUR CERTIFICATE BOOK. THIS INSERT IS PART OF YOUR CERTIFICATE AND SUBJECT TO CHANGE. FOR FURTHER EXPLANATION REFER TO YOUR CERTIFICATE BOOK.

Benefit Period (used for Deductible and Coinsurance limits)	January 1 through December 31 (Calendar Year)
Deductible (Applies to Network and Non-Network Benefits combined)	
Individual	$1,500
Family (may be met collectively)	$3,000
Note: All services are subject to the Deductible unless otherwise specified.	
Carry-Over Deductible Period	October, November and December
Network Coinsurance Limit: (Includes Network and Non-Network)	
Individual	$4,500
Family (may be met collectively)	$9,000
Deductible and Network Coinsurance Limit:	
Individual	$6,000
Family (may be met collectively)	$12,000
Non-Network Coinsurance Limit: (In addition to the Deductible and Network Coinsurance Limit.)	
Individual	$2,500
Family (may be met collectively)	$5,000
Maximum Out of Pocket (Deductible, Network and Non-Network Coinsurance Limits combined):	
Individual	$8,500
Family (may be met collectively)	$17,000
Lifetime Maximum Benefit For all Covered Services (in addition to the lifetime maximums for Organ Transplants and Bone Marrow Procedures)	$2,000,000 per Covered Person

BENEFIT HIGHLIGHTS

	NETWORK	NON-NETWORK
Office Visit / Office Consultation - Applies to charge for visit only. Does not apply to other services received during visit. Office Visit Fees do not apply to Deductible or Copayment limits.	$25 per Office Visit; 100% thereafter, No Deductible	$25 per Office Visit; 50% thereafter, No Deductible
Emergency Accident Care / Emergency Medical Care in the ER	$100 ER copay 70% after deductible	$100 ER copay 50% after deductible
Prescription Drugs are provided through a Preferred Pharmacy Network - Members will be required to pay the difference between the brand and generic allowance in addition to the coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists. Maximum 34 day supply.	Member pays 30% or $10 Minimum Coinsurance whichever is greater, No Deductible	NO BENEFITS
Mail Order Drugs - Members will be required to pay the difference between the brand and generic allowance in addition to the coinsurance, unless the physician writes "brand necessary" (DAW) on the prescription, or if no generic equivalent exists. Maximum 90 day supply.	Member pays 30% or $30 Minimum Coinsurance whichever is greater, No Deductible	NO BENEFITS

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PREVENTIVE CARE SERVICES

	NETWORK	NON-NETWORK
Annual Gynecological Exam - one per calendar year	$25 per Office Visit; 100% thereafter, No Deductible	$25 per Office Visit; 50% thereafter, No Deductible
Routine Pap Smears - one per calendar year **Routine HPV Testing -** one every 3 years age 30 and older	70%	50%
Routine Mammogram - per schedule age 35 and older	70%	50%
Prostate Exam - one per calendar year for males over age 50.	$25 per Office Visit; 100% thereafter, No Deductible	$25 per Office Visit; 50% thereafter, No Deductible
Prostate Specific Antigen (PSA) Test - one per calendar year	70%	50%
Colorectal Cancer Exam - for individual's age 50 and older or a symptomatic person under age 50. One per calendar year.	$25 per Office Visit; 100% thereafter, No Deductible	$25 per Office Visit; 50% thereafter, No Deductible
Fecal occult blood test - one per calendar year	70%	50%
Flexible Sigmoidoscopy - one every 5 years	70%	50%
Colonoscopy - one every 10 years	70%	50%
Double Contrast Barium Enema - one every 5 years	70%	50%
Routine Physical Exam - one per calendar year	$25 per Office Visit; 100% thereafter, No Deductible	$25 per Office Visit; 50% thereafter, No Deductible
Routine Diagnostic Services - see certificate book for list of covered diagnostics	70%	50%
Adult Immunizations - see certificate book for list of covered immunizations	70%	50%
Diabetes Education & Control - refresher education limited to $100 per CY	$25 per Office Visit, 100% thereafter, No Deductible 70% other services, Subject to Deductible	$25 per Office Visit, 50% thereafter, No Deductible 50% other services, Subject to Deductible

WELL BABY / CHILD CARE SERVICES

	NETWORK	NON-NETWORK
Well Baby Care - routine office visits, lab tests and immunizations to age 6.	100%, No Deductible	100%, No Deductible
Well Child Care - Routine office visits and immunizations age 6 through 17.	100%, No Deductible	100%, No Deductible

PHYSICIAN SERVICES

	NETWORK	NON-NETWORK
In-Hospital Medical Visit	70%	50%
Surgery, Assistant to Surgery, Anesthesia	70%	50%
Second Surgical Opinion Services (outpatient)	100%, No Deductible	100%, No Deductible
Maternity Care - Dependent daughters are NOT covered.	70%	50%
Newborn Care including circumcision.	70%	50%
Occupational, Physical Therapy and Chiropractic Manipulations **Note:** Limitations are Physician and Outpatient Facility services combined (per calendar year). Coinsurances for these services do not apply to your Coinsurance Limits.	70% for the first 20 treatments, 50% thereafter	50%
Respiratory, Hyperbaric and Pulmonary Therapy	70%	50%
Speech Therapy when necessary due to a medical condition.	70%	50%
Rehabilitation Services	70%	50%
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	70%	50%
Diagnostic, X-ray, Lab and Testing	70%	50%
Allergy Testing and Treatment	70%	50%
Outpatient Mental Health Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity. If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. **Note:** Limitations are Physician and Outpatient Facility services combined (per calendar year). Coinsurances for these services do not apply to your Coinsurance Limits.	70% for the first 20 treatments, 50% thereafter, if medically necessary	50%
Outpatient Drug Abuse Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity. If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. **Note:** Limitations are Physician and Outpatient Facility services combined (per calendar year). Coinsurances for these services do not apply to your Coinsurance Limits.	70% for the first 20 treatments, 50% thereafter, if medically necessary	50%
Outpatient Alcoholism Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity. If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. **Note:** Limitations are Physician and Outpatient Facility services combined (per calendar year). Coinsurances for these services do not apply to your Coinsurance Limits.	70% for the first 20 treatments, 50% thereafter, if medically necessary	50%

INPATIENT HOSPITAL / FACILITY SERVICES		
	NETWORK	**NON-NETWORK**
Unlimited Days Semi-Private Room and Board **Note:** If admission is not Precertified, you pay a $500 Precertification review Penalty.	70%	50%
Ancillaries, Drugs, Therapy Services, X-ray and Lab	70%	50%
General Nursing Care	70%	50%
Surgical Services	70%	50%
Birthing Center Care / Maternity Services - Dependent daughters are NOT covered.	70%	50%
Inpatient Mental Health Care Services - If admission is not precertified you pay a $500 Precertification review penalty.	70%	50%
Inpatient Drug Abuse Services - If admission is not precertified you pay a $500 Precertification review penalty.	70%	50%
Inpatient Alcoholism Services - If admission is not precertified you pay a $500 Precertification review penalty.	70%	50%

OUTPATIENT HOSPITAL / FACILITY SERVICES		
	NETWORK	**NON-NETWORK**
Non-Emergency Medical Care in the ER	$100 ER copay 70% after deductible	$100 ER copay 50% after deductible
Pre-Admission Testing	70%	50%
Diagnostic, X-ray, Lab and Testing	70%	50%
Surgery, Operating Room	70%	50%
Radiation and Chemotherapy	70%	50%
Occupational and Physical Therapy - Note: Limitations are Physician and Outpatient Facility services combined (per calendar year). Coinsurances for these services do not apply to your Coinsurance Limits.	70% for the first 20 treatments, 50% thereafter	50%
Respiratory, Hyperbaric and Pulmonary Therapy	70%	50%
Speech Therapy when necessary due to a medical condition.	70%	50%
Rehabilitation Services	70%	50%
Outpatient Mental Health Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity. If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. **Note:** Limitations are Physician and Outpatient Facility services combined (per calendar year). Coinsurances for these services do not apply to your Coinsurance Limits.	70% for the first 20 treatments, 50% thereafter, if medically necessary	50%
Outpatient Drug Abuse Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity. If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. **Note:** Limitations are Physician and Outpatient Facility services combined (per calendar year). Coinsurances for these services do not apply to your Coinsurance Limits.	70% for the first 20 treatments, 50% thereafter, if medically necessary	50%
Outpatient Alcoholism Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity. If treatment plan is not submitted or approved, additional visits will be denied as not medically necessary. **Note:** Limitations are Physician and Outpatient Facility services combined (per calendar year). Coinsurances for these services do not apply to your Coinsurance Limits.	70% for the first 20 treatments, 50% thereafter, if medically necessary	50%

OTHER COVERED SERVICES		
	NETWORK	NON-NETWORK
Private Duty Nursing - $5,000 Maximum per calendar year **Note:** Maximums are Network and Non-Network combined.	70%	50%
Skilled Nursing Facility - $10,000 Maximum per calendar year **Note:** If admission is not Precertified, you pay a $500 Precertification review penalty.. **Maximums are Network and Non-Network combined.**	70%	50%
Durable Medical Equipment and Oxygen at home	70%	50%
Medical and Surgical Supplies	70%	50%
Orthotic Devices and Prosthetic Appliances	70%	50%
Home Health Care - Maximum 100 visits **Note:** Maximums are Network and Non-Network combined.	70%	50%
Emergency Ambulance	100%, No Deductible	100%, No Deductible
Other Ambulance Services	70%	50%
Hospice Care	70%	50%

HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES		
	NETWORK	NON-NETWORK
Human Organ Transplant • $2,000,000 lifetime maximum per type of transplant • $25,000 for acquisition, storage and transport of organ • $150 per day to a maximum of $10,000 for transportation, meals and lodging. Note: Benefit is in addition to the lifetime medical maximum.	70%	50%
Bone Marrow Procedures • $2,000,000 lifetime maximum per cause of transplant for all procedures combined • $150 per day to a maximum of $10,000 for transportation, meals and lodging. Note: Benefit is in addition to the lifetime medical maximum.	70%	50%

Eligible Dependent Age Limitation	Coverage stops at the end of the month of age 19 for a child which is an Eligible Dependent, but will continue to the end of the month the individual reaches the age of 25 if the adult child is unmarried and is either a full-time student or meets the criteria for Qualified Child or Qualified Relative under IRS rules.

Precertification Requirement	Penalty of no Pre-Certification is $500 reduction of benefits per Inpatient admission

Preexisting Condition Limitation	Preexisting Condition Waiting Period: "If you were enrolled in another health insurance policy prior to the Effective Date of your coverage under this Contract, the length of time you were covered under the previous policy will be applied to the Preexisting Condition Waiting Period. If there is a 63 day lapse in coverage, the 365 day waiting period will apply."

ALL SERVICES ARE SUBJECT TO A DETERMINATION OF MEDICAL NECESSITY BY MOUNTAIN STATE BLUE CROSS BLUE SHIELD. PAYMENT IS BASED ON THE ACTUAL CHARGES, PROFESSIONAL ALLOWANCE OR PROVIDERS REASONABLE CHARGE. IN ADDITION, YOU WILL BE RESPONSIBLE FOR THE NON-NETWORK LIABILITY.