



A HIGHMARK AFFILIATE

An Independent Licensee of the Blue Cross and Blue Shield Association

# SuperBlue Plus 2008

## \$2,500 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.

<b>Benefit Period</b> (used for Deductible and Coinsurance limits)	January 1 through December 31 (Calendar Year)
<b>Deductible</b> (Applies to Network and Non-Network Benefits combined)	
Individual	\$2,500
Family (may be met collectively)	\$5,000
<b>Note: All services are subject to the Deductible unless otherwise specified.</b>	
<b>Carry-Over Deductible Period</b>	October, November and December
<b>Network Coinsurance Limit:</b> (Includes Network and Non-Network)	
Individual	\$4,500
Family (may be met collectively)	\$9,000
<b>Deductible and Network Coinsurance Limit:</b>	
Individual	\$7,000
Family (may be met collectively)	\$14,000
<b>Non-Network Coinsurance Limit:</b> (In addition to the Deductible and Network Coinsurance Limit.)	
Individual	\$2,500
Family (may be met collectively)	\$5,000
<b>Maximum Out of Pocket</b> (Deductible, Network and Non-Network Coinsurance Limits combined):	
Individual	\$9,500
Family (may be met collectively)	\$19,000
<b>Lifetime Maximum Benefit</b> 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
<b>Office Visit / Office Consultation</b> - Applies to charge for visit only. Does not apply to other services received during visit. Office Visit Fees do not apply to Deductible or Coinsurance limits.	\$25 per Office Visit; 100% thereafter, No Deductible	\$25 per Office Visit; 50% thereafter, No Deductible
<b>Emergency Accident Care / Emergency Medical Care in the ER</b>	\$100 ER copay 70% after deductible	\$100 ER copay 50% after deductible
<b>Prescription Drugs are provided through a Preferred Pharmacy Network</b> - 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. 34 day supply.	Member pays 30% or \$10 Minimum Coinsurance whichever is greater, No Deductible	NO BENEFITS
<b>Mail Order Drugs</b> - 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

©Registered Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. Mountain State Blue Cross & Blue Shield is an Independent Licensee of the Blue Cross Blue Shield Association.

PREVENTIVE CARE SERVICES		
	NETWORK	NON-NETWORK
<b>Annual Gynecological Exam - one per calendar year</b>	\$25 per Office Visit; 100% thereafter, No Deductible	\$25 per Office Visit; 50% thereafter, No Deductible
<b>Routine Pap Smears - one per calendar year</b>	70%	50%
<b>Routine HPV Testing - one every 3 years age 30 and older</b>	70%	50%
<b>Routine Mammogram - per schedule age 35 and older</b>	70%	50%
<b>Prostate Exam - one per calendar year for males over age 50.</b> Prostate Specific Antigen (PSA) Test - one per calendar year	\$25 per Office Visit; 100% thereafter, No Deductible 70%	\$25 per Office Visit; 50% thereafter, No Deductible 50%
<b>Colorectal Cancer Exam - for individual's age 50 and older or a symptomatic person under age 50. One per calendar year.</b> Fecal occult blood test - one per calendar year Flexible Sigmoidoscopy - one every 5 years Colonoscopy - one every 10 years Double Contrast Barium Enema - one every 5 years	\$25 per Office Visit; 100% thereafter, No Deductible 70% 70% 70% 70%	\$25 per Office Visit; 50% thereafter, No Deductible 50% 50% 50% 50%
<b>Routine Physical Exam - one per calendar year</b>	\$25 per Office Visit; 100% thereafter, No Deductible	\$25 per Office Visit; 50% thereafter, No Deductible
<b>Routine Diagnostic Services - see certificate book for list of covered diagnostics</b>	70%	50%
<b>Adult Immunizations - see certificate book for list of covered immunizations</b>	70%	50%
<b>Diabetes Education &amp; Control - refresher education limited to \$100 per CY</b>	\$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
<b>Well Baby Care - routine office visits, lab tests and immunizations to age 6.</b>	100%, No Deductible	100%, No Deductible
<b>Well Child Care - Routine office visits and immunizations age 6 through 17.</b>	100%, No Deductible	100%, No Deductible
PHYSICIAN SERVICES		
	NETWORK	NON-NETWORK
<b>In-Hospital Medical Visit</b>	70%	50%
<b>Surgery, Assistant to Surgery, Anesthesia</b>	70%	50%
<b>Second Surgical Opinion Services (outpatient)</b>	100%, No Deductible	100%, No Deductible
<b>Maternity Care - Dependent daughters are NOT covered.</b>	70%	50%
<b>Newborn Care including circumcision.</b>	70%	50%
<b>Occupational, Physical Therapy and Chiropractic Manipulations</b> <b>Note:</b> 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%
<b>Respiratory, Hyperbaric and Pulmonary Therapy</b>	70%	50%
<b>Speech Therapy when necessary due to a medical condition.</b>	70%	50%
<b>Rehabilitation Services</b>	70%	50%
<b>Temporomandibular Joint Dysfunction / Craniomandibular Disorders</b>	70%	50%
<b>Diagnostic, X-ray, Lab and Testing</b>	70%	50%
<b>Allergy Testing and Treatment</b>	70%	50%
<b>Outpatient Mental Health Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity.</b> If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. <b>Note:</b> 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%
<b>Outpatient Drug Abuse Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity.</b> If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. <b>Note:</b> 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%
<b>Outpatient Alcoholism Services - Treatment Plan is required prior to the 9th treatment to determine medical necessity.</b> If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. <b>Note:</b> 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
<b>Unlimited Days Semi-Private Room and Board</b> <b>Note:</b> If admission is not Precertified, you pay a \$500 Precertification review Penalty.	70%	50%
<b>Ancillaries, Drugs, Therapy Services, X-ray and Lab</b>	70%	50%
<b>General Nursing Care</b>	70%	50%
<b>Surgical Services</b>	70%	50%
<b>Birthing Center Care / Maternity Services</b> - Dependent daughters are NOT covered.	70%	50%
<b>Inpatient Mental Health Care Services</b> - If admission is not precertified you pay a \$500 Precertification review penalty.	70%	50%
<b>Inpatient Drug Abuse Services</b> - If admission is not precertified you pay a \$500 Precertification review penalty.	70%	50%
<b>Inpatient Alcoholism Services</b> - If admission is not precertified you pay a \$500 Precertification review penalty.	70%	50%
OUTPATIENT HOSPITAL / FACILITY SERVICES		
	NETWORK	NON-NETWORK
<b>Non-Emergency Medical Care in the ER</b>	\$100 ER copay 70% after deductible	\$100 ER copay 50% after deductible
<b>Pre-Admission Testing</b>	70%	50%
<b>Diagnostic, X-ray, Lab and Testing</b>	70%	50%
<b>Surgery, Operating Room</b>	70%	50%
<b>Radiation and Chemotherapy</b>	70%	50%
<b>Occupational and Physical Therapy</b> - <b>Note:</b> 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%
<b>Respiratory, Hyperbaric and Pulmonary Therapy</b>	70%	50%
<b>Speech Therapy</b> when necessary due to a medical condition.	70%	50%
<b>Rehabilitation Services</b>	70%	50%
<b>Outpatient Mental Health Services</b> - <b>Treatment Plan is required prior to the 9th treatment to determine medical necessity.</b> If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. <b>Note:</b> 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%
<b>Outpatient Drug Abuse Services</b> - <b>Treatment Plan is required prior to the 9th treatment to determine medical necessity.</b> If treatment plan is not submitted or approved, additional treatments will be denied as not medically necessary. <b>Note:</b> 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%
<b>Outpatient Alcoholism Services</b> - <b>Treatment Plan is required prior to the 9th treatment to determine medical necessity.</b> If treatment plan is not submitted or approved, additional visits will be denied as not medically necessary. <b>Note:</b> 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%

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

<b>HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES</b>		
	<b>NETWORK</b>	<b>NON-NETWORK</b>
<b>Human Organ Transplant</b> <ul style="list-style-type: none"> <li>• \$2,000,000 lifetime maximum per type of transplant</li> <li>• \$25,000 for acquisition, storage and transport of organ</li> <li>• \$150 per day to a maximum of \$10,000 for transportation, meals and lodging.</li> </ul> <b>Note:</b> Benefit is in addition to the lifetime medical maximum.	70%	50%
<b>Bone Marrow Procedures</b> <ul style="list-style-type: none"> <li>• \$2,000,000 lifetime maximum per cause of transplant for all procedures combined</li> <li>• \$150 per day to a maximum of \$10,000 for transportation, meals and lodging.</li> </ul> <b>Note:</b> 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.**