Blue Cross of Idaho

Coldwater Creek medical benefit highlights

SUMMARY OF BENEFITS (Effective Date: 7/1/09)		Preferred Blue® Large Group	
Benefit Period* Deductible (Individual/Family)		Salaried: $500/$1,000 Hourly: $250/$500	
Coinsurance		You pay 20% of the allowed amount for covered services	You pay 30% of the allowed amount for covered services
Individual Out-of-Pocket Limit (Does not include: deductible, in-network copayments, drugs, dental and vision, non-covered services and charges over the allowed amount.)		$2,000	
Family Out-of-Pocket Limit (Does not include: deductible, in-network copayments, drugs, dental and vision, non-covered services and charges over the allowed amount.)		$4,000	
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 30% of the amount charged
Ambulance Transportation Services	Yes	You pay 20% of the allowed amount	
Chiropractic Care (Limited to $800 combined 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 30% 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 $25 copayment per visit	Not covered, you pay 100% of the billed charges
Diagnostic Services (including diagnostic mammogram)	Yes	You pay 20% of the allowed amount	You pay 30% of the allowed amount
Durable Medical Equipment			
Emergency Services			
Home Health Skilled Nursing (Limited to $5,000 combined 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 30% 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 30% of the allowed amount
Mental Health • Inpatient (Limited to 10 inpatient days per insured, per benefit period. • Outpatient (Limited to 18 outpatient visits per insured, per benefit period.)	Yes	You pay 20% of the allowed amount You pay 50% of the allowed amount	Not covered, you pay 100% of the amount charged

SUMMARY OF BENEFITS (Effective Date: 7/1/09)		Preferred Blue® Large Group	
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	
Orthotic Devices	Yes	You pay 20% of the allowed amount	You pay 30% of the allowed amount
Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to $2,000 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 $25 copayment	You pay 30% 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 combined 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.	Not covered, you pay 100% of the billed charges
Immunizations (See policy for specifically listed immunizations.)	No	You pay nothing for listed immunizations	

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

Prescription Drug Option	
Retail Prescription Drugs (30 day supply, 1 copayment)	
Generic	You pay a $0 copayment only
Brand Name	You pay a $30 copayment only
Non-Formulary	You pay a $50 copayment only
Mail Order Prescription Drugs (90 day supply, 1 copayment)	
Generic	You pay an $8 copayment only
Brand Name	You pay a $30 copayment only
Non-Formulary	You pay a $50 copayment only
Smoking Cessation (Retail and Mail order)	BCI pays up to $600 per Insured, per Benefit Period (Benefits are limited to a 30-day supply at one time.)

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.
Non-contracting providers may bill you for amounts over the maximum allowance.