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Coeur d'Alene School District Plan 2 Benefit Summary Effective 10/2007

This summary provides a brief description of your health care plan benefits and is not a guarantee of benefit payment. Benefit payments will be made based upon policy provisions and eligibility criteria. Please refer to your policy for a complete explanation of benefits, limitations, exclusions, and general provisions.

Maximum Benefits	(In-network and out-of-network combined): \$1,000,000 during an Insured's lifetime with automatic reinstatement up to \$5,000 each calendar year.
Deductible	<ul style="list-style-type: none"> • In-network: \$200 per Insured each calendar year; no family shall be obligated to meet more than \$400 in the aggregate in any calendar year. • Out-of-network: \$750 per Insured each calendar year; no family shall be obligated to meet more than \$1,500 in the aggregate in any calendar year.
Out-of-Pocket Expense	<ul style="list-style-type: none"> • In-network: \$2,500 per Insured each calendar year (plus deductible); no family shall be obligated to meet more than \$3,500 in the aggregate in any calendar year. • Out-of-network: \$3,500 per Insured each calendar year (plus deductible); no family shall be obligated to meet more than \$7,000 in the aggregate in any calendar year.
Human Organ and Tissue Transplants	Subject to the Policy's \$1,000,000 lifetime maximum.

Benefits	Network Provider Services You Pay	Services not provided by a Network Provider You Pay
Ambulance Services (prior review required for air ambulance)	10% coinsurance	50% coinsurance
Blood and Blood Plasma	10% coinsurance	50% coinsurance
Chemical Dependency and Mental Health		
• Outpatient services (30 visits calendar year maximum)	50% coinsurance	50% coinsurance
• Inpatient services (15 days calendar year maximum)	20% coinsurance	50% coinsurance
Chiropractic Services (\$800 calendar year maximum)	10% coinsurance	50% coinsurance
Contraceptives (enrolled employee, spouse, and dependent children)	Not subject to the deductible	
• Oral contraceptive prescription drugs	Subject to prescription drug benefit	Subject to prescription drug benefit
• Diaphragms and intrauterine devices	\$25 copayment per device	50% coinsurance
• Injectable contraceptives (Depo Provera)	\$20 copayment per injection	50% coinsurance
• Norplant insertion	\$100 copayment per implant	50% coinsurance
Diabetic Education (\$1,200 lifetime maximum)	Not subject to the deductible	
	10% coinsurance	50% coinsurance

Benefits	Network Provider Services You Pay	Services not provided by a Network Provider You Pay
Durable Medical Equipment; Orthotics; and Prosthetic Devices	10% coinsurance	50% coinsurance
Eye Examination (one examination per calendar year maximum)	Not subject to the deductible \$40 copayment per visit	All charges
Home Health Care (\$5,000 calendar year maximum)	10% coinsurance	50% coinsurance
Home Infusion Therapy	10% coinsurance	50% coinsurance
Hospice Care (\$5,000 lifetime maximum)	10% coinsurance	50% coinsurance
Hospital Care <ul style="list-style-type: none"> • Outpatient services (surgery, laboratory and x-ray charges, surgery suite, and ambulatory surgical center) • Emergency room charge for treatment of illness and injury • Inpatient services (room and board and general nursing care, cardiac or intensive care units, ancillary services and supplies, and routine newborn care) 	10% coinsurance 10% coinsurance 10% coinsurance	50% coinsurance 50% coinsurance 50% coinsurance
Human Growth Hormone Therapy (\$25,000 calendar year maximum)	10% coinsurance	50% coinsurance
Injury to a Sound Natural Tooth (12 months from date of accident)	10% coinsurance	50% coinsurance
Mammography Services (see Physician Services)		
Maternity Care (benefits are not provided for dependent children) <ul style="list-style-type: none"> • Physician services (prenatal and delivery) • Hospital services (room and board and general nursing care) 	10% coinsurance 10% coinsurance	50% coinsurance 50% coinsurance
Mental Health (see Chemical Dependency)		
Physician Services <ul style="list-style-type: none"> • Office, home, outpatient hospital visits, and surgical opinions • Office or outpatient hospital surgery, inpatient hospital visits, and routine newborn care • Laboratory and x-ray, including mammography, for illness and routine services 	\$25 copayment per visit, not subject to the deductible 10% coinsurance First \$250 – no coinsurance required; then subject to the deductible and 10% coinsurance	50% coinsurance 50% coinsurance 50% coinsurance
Prescription Drugs (one copayment for each 30-day supply, not to exceed 90-day supply. Mail-order program network only benefit: one copayment per 30-day supply, limited to 90-day supply.) <ul style="list-style-type: none"> • Generic • Formulary brand name • Non-formulary brand name • Diabetic supplies (blood sugar diagnostics, lancets, swabs, and urine test strips) 	Not subject to the deductible \$10 copayment \$25 copayment \$40 copayment Subject to prescription drug benefit – copayment per item	Not subject to the deductible \$10 copayment \$25 copayment \$40 copayment Subject to prescription drug benefit – copayment per item

Benefits	Network Provider Services You Pay	Services not provided by a Network Provider You Pay
Preventive Care <ul style="list-style-type: none"> • Routine physical examinations and outpatient well baby care • Immunizations • Routine laboratory and x-ray charges, including routine mammography services 	\$20 copayment per visit, not subject to the deductible No coinsurance required, not subject to the deductible See Physician Services	50% coinsurance No coinsurance required 50% coinsurance
Rehabilitation <ul style="list-style-type: none"> • Inpatient services (\$150,000 lifetime maximum) • Outpatient services (\$800 calendar year maximum per each physical, respiratory, occupational, and speech therapy) 	10% coinsurance 10% coinsurance	50% coinsurance 50% coinsurance
Skilled Nursing Facility (30 days calendar year maximum)	10% coinsurance	50% coinsurance
Specialist Services <ul style="list-style-type: none"> • Office, home, outpatient hospital visits, and surgical opinions • Office or outpatient hospital surgery, inpatient hospital visits, and routine newborn care • Laboratory and x-ray, including mammography, for illness and routine services 	\$40 copayment per visit, not subject to the deductible 10% coinsurance See Physician Services	50% coinsurance 50% coinsurance 50% coinsurance
Urgent Care <ul style="list-style-type: none"> • RegionalCare network providers • AccessCare network providers 	Not subject to the deductible \$25 copayment per visit \$40 copayment per visit	50% coinsurance 50% coinsurance

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