



Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Sage Technical Services

\$2,000 Deductible Limited Benefit Health Plan Benefit Summary Effective 1/2011

This is a limited benefit health plan that provides inpatient hospital benefits and limited outpatient benefits. Benefits provided are not intended to cover all medical expenses. This summary provides a brief description of your limited health plan benefits and is not a guarantee of benefit payment. Benefit payments will be made based upon policy provisions and eligibility criteria. Coverage is provided for covered services provided by both preferred and non-preferred providers. Preferred providers agree to accept the allowed amount for covered services. You will be responsible for the difference between the allowed amount and the billed charges, in addition to the responsibility shown below, when covered services are received from a non-preferred provider. Please refer to your benefit booklet for a complete explanation of benefits, limitations, exclusions, and general provisions.

Annual Maximum	\$2,000,000 per Insured each calendar year
Deductible	Preferred and Non-Preferred Providers (combined): \$2,000 per Insured each calendar year. No family shall be obligated to meet more than \$4,000 in the aggregate in any calendar year. Benefits are payable after the deductible has been met.
Out-of-Pocket Expense	Preferred Providers: \$2,500 per Insured each calendar year (plus deductible). Non-Preferred Providers: \$3,500 per Insured each calendar year (plus deductible).
Please Note: Insureds must access Preferred Providers in the state of Idaho and those states where Preferred Provider networks are available in order to receive Preferred Provider benefits.	

BENEFIT	AMOUNT YOU PAY
Ambulance Services	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
Blood and Blood Plasma	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
Contraceptives	Not subject to the deductible
• Oral contraceptive prescription drugs	Subject to prescription drug benefit
• Diaphragms and intrauterine devices	\$25 copayment per device 50% coinsurance
√ Preferred Provider	
√ Non-Preferred Provider	
• Injectable contraceptives (Depo Provera)	\$20 copayment per injection 50% coinsurance
√ Preferred Provider	
√ Non-Preferred Provider	
• Norplant insertion	\$100 copayment per implant 50% coinsurance
√ Preferred Provider	
√ Non-Preferred Provider	

BENEFIT	AMOUNT YOU PAY
Diabetic Education <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 20% coinsurance
Diabetic Supplies (blood sugar diagnostics, lancets, swabs, and urine test strips) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance
Durable Medical Equipment (blood glucose monitors, insulin infusion devices, and insulin pumps; and lifesaving equipment such as ventilators and oxygen) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance
Home Health Care (60 visits calendar year maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance
Hospice Care (inpatient/outpatient combined 14 days lifetime maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance
Hospital Care <ul style="list-style-type: none"> • Outpatient surgical services <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider • Emergency room charge (copayment is in addition to deductible and coinsurance) <ul style="list-style-type: none"> √ Preferred or Non-Preferred Provider <p>Note: See the Outpatient Laboratory and X-Ray Services section for benefits for outpatient laboratory and x-ray charges.</p> <ul style="list-style-type: none"> • Inpatient services <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	20% coinsurance 50% coinsurance \$100 copayment per visit, plus 20% coinsurance 20% coinsurance 50% coinsurance
Human Organ and Tissue Transplants <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	20% coinsurance 50% coinsurance
Mammography Services (illness and injury services) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance
Maternity Care (benefits are not provided for children) <ul style="list-style-type: none"> • Physician services (prenatal and delivery) <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider • Hospital services (room and board and general nursing care) <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	20% coinsurance 50% coinsurance 20% coinsurance 50% coinsurance
Outpatient Laboratory and X-ray Services <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance

BENEFIT	AMOUNT YOU PAY
Phenylketonuria Formulas (PKU) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance
Physician Services <ul style="list-style-type: none"> • Office, home, outpatient hospital visits, and 2nd and 3rd surgical opinions (4 visits calendar year maximum) <ul style="list-style-type: none"> √ Preferred and Non-Preferred Physician that provides primary health care needs and specializes in family practice, internal medicine, pediatrics, or obstetrics/ gynecology. √ Preferred and Non-Preferred Physician that provides care for a particular disease and/or condition and specializes in such areas as gastroenterology, cardiology, dermatology, neurology, or oncology. <p>Note: See the Outpatient Laboratory and X-Ray Services section for outpatient laboratory and x-ray benefits.</p> <ul style="list-style-type: none"> • Inpatient hospital visits, surgeon fees, and routine newborn care <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	\$25 copayment per visit, not subject to the deductible \$40 copayment per visit, not subject to the deductible 20% coinsurance 50% coinsurance
Prescription Drugs (34 day supply or 100-unit doses, whichever is less. Mail-order program: one copayment/coinsurance per each 30 day supply, not to exceed a 90 day supply) <ul style="list-style-type: none"> • Generic • Formulary brand name • Non-formulary brand name <p>Out-of-pocket expense – Formulary and Non-formulary combined (\$5,000 calendar year maximum)</p> <p>Note: A 90 day supply (copayment applies to each 30 day supply) of generic maintenance drugs may be purchased from a retail pharmacy, subject to the copayment for generic drugs.</p>	Not subject to the deductible \$10 copayment 35% coinsurance 50% coinsurance
Preventive Care <ul style="list-style-type: none"> • Preferred Providers or a Non-Preferred Provider who is contracted with Regence BSI <ul style="list-style-type: none"> √ Routine visits for preventive care including well-baby care, screenings for women and routine physical exams √ Routine radiology and laboratory services including mammography and prostate screening √ Routine procedures including routine colonoscopies √ Immunizations for adults and children • Non-Preferred Providers who do not otherwise have a contract with Regence BSI <ul style="list-style-type: none"> √ Routine visits for preventive care including well-baby care, screenings for women and routine physical exams √ Routine radiology and laboratory services including mammography and prostate screening √ Routine procedures including routine colonoscopies √ Immunizations for adults and children <p>Note: Preventive care services are not subject to the Preferred and Non-Preferred Provider 4 office visit calendar year maximum.</p>	Not subject to the deductible No coinsurance required No coinsurance required No coinsurance required No coinsurance required \$25 copayment per visit No coinsurance required No coinsurance required No coinsurance required
Preventive Medications (covered according to federal guidelines, with no coinsurance, no deductible, and no copayment at participating pharmacies only)	No coinsurance required, not subject to the deductible

BENEFIT	AMOUNT YOU PAY
Prosthetic Devices (external and internal breast prostheses)	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
Rehabilitation – Inpatient Services (15 days per calendar year maximum)	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
Skilled Nursing Facility (30 days calendar year maximum)	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance

PREEXISTING CONDITION EXCLUSION

Exclusion Period for Preexisting Conditions: 12 months (credit may be given for prior qualifying previous coverage). Exclusion Period does not apply to Insureds enrolled prior to reaching nineteen (19) years of age.

Important note: Preexisting condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period immediately preceding the effective date of coverage.

Qualifying Previous Coverage means with respect to an individual, health benefits or coverage provided under any of the following: Group health benefit plan; Health insurance coverage without regard to whether the coverage is offered in the group market, individual market or otherwise; Medicare; Medicaid; medical and dental care for members and certain former members of the uniformed services and their dependents (“uniformed services” means the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Public Health Service); a medical care program of the Indian Health Services or of a tribal organization; a state high-risk pool coverage; Federal Employees Health Benefits Program (FEHBP); a public health plan (a plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage to individuals enrolled in the plan); or a health plan issued under the Peace Corps Act. A state Children’s Health Insurance Program (CHIP), is creditable coverage, whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

EXCLUSIONS

Benefits will not be provided in any of the following circumstances or for any of the following conditions under the terms of the policy. However, these exclusions shall not apply with regard to an otherwise Covered Service 1) an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or 2) a preventive service as specified under the Preventive Care benefit of the policy.

- To the extent benefits are provided or covered by any governmental agency, except as otherwise provided by law.
- Expenses for services incurred as a result of any work related injury or illness, including any claims that are resolved pursuant to a disputed claim settlement for which the Insured has or had a right to compensation.
- Any injury or illness resulting from any act of war or from explosion of atomic or similar fissionable materials in war (declared or undeclared) or any illness or injury contracted or incurred during military service, including any complications or recurrences thereof, or national disaster.
- Any situation in which no specific medical treatment plan or psychiatric plan is furnished, including but not limited to rest cure, detoxification setup, custodial care, etc.
- Home infusion therapy.
- Hospital benefits when hospitalization is primarily for diagnostic studies or physical therapy when such procedures could have been done adequately and safely on an outpatient basis.
- Pregnancy tests unless provided by a physician and administered in the physician's office or in the hospital.

- Maternity benefits (including involuntary complications of pregnancy) for dependent children.
- Immunizations required for travel abroad, including but not limited to cholera, plague, typhoid, typhus, and yellow fever when services are provided by a Non-Preferred Provider who does not otherwise have a contract with Regence BSI.
- Laetrile (amygdalin); acupuncture; chelation therapy (except for lead poisoning); homeopathic services; naturopathic services; thermography; massage therapy.
- Routine eye refraction; eye glasses; visual therapy or training.
- Radial keratotomy (refractive keratoplasty or other surgical procedures to correct refractive errors/astigmatism).
- Routine hearing examinations; hearing aids.
- Humidifiers; vaporizers; air conditioners; or any other air filtration or purification unit or system.
- Physical fitness or physical therapy equipment including, but not limited to, whirlpools, spas, hot tubs; weight lifting equipment; charges in or by health spas; weight reduction programs.
- Cosmetic and/or reconstructive services and supplies, including services and supplies related to a previous cosmetic procedure or complications of a previous cosmetic procedure, except as follows:
 - √ Related to breast reconstruction following a mastectomy to the extent required by law (refer to the Women's Health and Cancer Rights provision for additional information);
 - √ Due to a trauma, infection, or other disease of the involved part; or
 - √ Due to a congenital disease or anomaly for an insured child.
 - √ For the purposes of this exclusion, cosmetic means a procedure that primarily improves or changes appearance and does not primarily restore an impaired function of the body.
- Investigative treatment as determined by Regence BSI.
- Benefits which are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to the Insured, whether or not application is duly made therefore.
- Procedures related to sex transformations.
- Services and supplies for or in connection with: (1) infertility treatment, except to the extent covered services are required to diagnose such a condition, (2) reversal of sterilization; (3) surrogate pregnancy; (4) assisted reproductive technology (ART) procedures; and (5) fertility drugs and medications (Pergonal, etc.).
- Vasectomies (male sterilization) will be covered for physician services only.
- Treatment of sexual dysfunction or sexual inadequacy, including erectile dysfunction and impotence; and medications for impotency (Viagra, etc.).
- Outpatient rehabilitation services and supplies, including but not limited to physical, occupational, respiratory, or speech therapy.
- Outpatient cardiac and pulmonary rehabilitation therapies.
- Medical or surgical treatment for obesity and manifestations thereof, or for reversal or revisions of surgery for obesity.
- Benefits in connection with transplants, except as set forth in human organ and tissue transplants of the policy.
- Benefits in connection with harvesting and reinfusion of bone marrow for the treatment of any illness, except as set forth in the human organ and tissue transplants of the policy.
- Any services, chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs, and aftercare for or related to bone marrow transplant, stem cell support or peripheral stem cell support procedures for a condition not set forth in the human organ and tissue transplants of the policy.
- Birth control devices and/or birth control prescription drugs, unless benefits are provided by an endorsement to the policy.
- Outpatient prescription drugs, unless benefits are provided by an endorsement to the policy.

- Prescription drugs and medicines for smoking cessation.
- Human Growth Hormone therapy.
- Services and supplies provided by a chiropractor.
- Services and supplies for the treatment of mental or neuropsychiatric conditions, chemical dependency, alcoholism and/or drug addiction. Prescription medications for the treatment of mental or neuropsychiatric conditions, chemical dependency, alcoholism and/or drug addiction, unless prescription drug benefits are provided by an endorsement to the policy.
- Services connected with nonemergency, nonmaternity hospital admissions on Fridays or Saturdays, unless surgery is performed the day of admission or the day following admission.
- Termination of pregnancy (elective abortion), except when performed to preserve the life of the enrolled female Insured.
- Services and supplies related to dentistry, temporomandibular joint (TMJ) disorders, dental implants, orthodontic treatment, oral surgery (except for the treatment of a jaw fracture), orthognathic conditions, or orthognathic surgery, whether necessary due to an accident, disease, deformity, or dental treatment.
- Orthodontic bracing for treatment of temporomandibular joint (TMJ) disorders.
- Charges for services and supplies: (1) for which an Insured is not required to make payment, (2) that are made only because benefits are available under the Policy, or (3) for which an insured would have no legal obligation to pay in the absence of this or any similar coverage.
- Expenses for services furnished by a provider who is related to the Insured by blood or marriage or who resides in the Insured's household.
- Charges for telephone or internet consultations; missed appointments; claim form completion; interest charges; legal services; obtaining medical records; or provider travel and/or lodging expenses.
- Durable medical equipment, including but not limited to accessories and supplies used in conjunction with durable medical equipment, heating pads, contour chairs, therapeutic beds, hospital beds, setup and delivery of durable medical equipment, except as provided in the policy.
- Routine foot care (including removal of corns or calluses or trimming of nails); foot impression casting including x-rays incidental to casting; orthopedic shoes; arch supports and other supportive devices for the feet; and off-the-shelf shoe inserts.
- Orthotic devices, including but not limited to braces, splints, orthopedic appliances, and other orthotic supplies.
- Prosthetic devices, except for necessary prostheses following a mastectomy. See the prosthetic devices and Women's Health and Cancer Right sections of the policy.
- Convenience items such as telephones; television; guest trays or meals; personal hygiene items or services; or homemaker or housekeeping services, except by home health aides as ordered in a hospice treatment plan.
- Drugs and supplies not requiring a prescription order, including but not limited to aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, and bandages; Antabuse, Methadone, Minoxidil, or Rogaine hair preparations; experimental drugs including those labeled, "Caution-Limited by Federal Law to Investigational Use"; and prescription medications related to health care services which are not covered under the policy. Notwithstanding this exclusion, Regence BSI may choose to cover certain over-the-counter medications when prescription drug benefits are provided under the policy. Such approved over-the-counter medications must be identified by Regence BSI in writing and will specify the procedures for obtaining benefits for such approved over-the-counter medications. Please note that the fact a particular over-the-counter drug or medication is covered does not require Regence BSI to cover or otherwise pay or reimburse the Insured for any other over-the-counter drug or medication.
- Diet and weight monitoring, and educational services.
- Special foods or diets, vitamins, minerals, dietary and nutritional supplements, and nutritional therapy. See the Phenylketonuria Formulas section for PKU formulas benefits.
- Biofeedback.

- Wigs and artificial hair pieces.
- Any services, supplies, or charges which result from the treatment of any direct or indirect complication of any illness or condition for which coverage is not or was not provided.

LIMITATIONS

- Total benefits paid for office, home, and outpatient hospital visits, including second and third surgical consultative opinions shall be limited to a combined maximum of four (4) visits per Insured each calendar year for services provided by a preferred provider and non-preferred provider.
- Total benefits paid for Inpatient rehabilitation services shall be limited to a maximum of fifteen (15) days per Insured each calendar year.
- Total benefits paid for home health care visits shall be limited to a maximum of sixty (60) visits per Insured each calendar year.
- Total benefits paid for hospice care services shall be limited to a maximum of fourteen (14) days during an Insured's lifetime.
- Total benefits paid for extended care in a skilled nursing facility shall be limited to a maximum of thirty (30) days per Insured each calendar year.
- Claims submitted to Regence BSI more than twelve (12) months after the last day on which covered services were rendered shall be ineligible for payment, unless it can be shown to the satisfaction of Regence BSI that there was unusual and justifiable cause for such late submission.

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