



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

REGENCE SUMMIT

\$5,000 Deductible Benefit Summary

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.

Please note: All charges apply to deductible unless otherwise noted.

Maximum Benefits	\$2,000,000 during an Insured's lifetime.
Deductible	\$5,000 per Insured each calendar year; \$10,000 per family in the aggregate each calendar year. Maternity care is subject to a separate \$5,000 deductible per Insured. Benefits are payable after the deductible has been met.
Out-of-Pocket Expense	\$2,000 per Insured each calendar year; \$6,000 per family in the aggregate each calendar year. Does not include deductible.
Human Organ and Tissue Transplants	\$250,000 maximum during an Insured's lifetime.
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
Alternative Medicine including chiropractor, massage therapist, naturopath, and acupuncturist (\$500 combined calendar year maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	 20% coinsurance 40% coinsurance
Ambulance Services <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	 20% coinsurance 40% coinsurance
Blood and Blood Plasma <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	 20% coinsurance 40% coinsurance
Chemical Dependency (\$1,500 calendar year maximum for inpatient and outpatient services combined) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	 50% coinsurance 50% coinsurance
Contraceptives (policyholder, spouse, and dependent children) <ul style="list-style-type: none"> • Oral contraceptive prescription drugs • Diaphragms and intrauterine devices, injectable contraceptives (Depo Provera), and Norplant implants <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	 Subject to prescription drug benefit, not subject to the deductible 20% coinsurance 40% coinsurance
Diabetic Education (\$400 calendar year maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	 20% coinsurance 40% coinsurance

BENEFIT	AMOUNT YOU PAY
Diabetic Supplies (blood sugar diagnostic, lancets, swabs, and urine test strips) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Durable Medical Equipment; Orthotics; and Prosthetic Devices <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Home Health Care (\$5,000 calendar year maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Home Infusion Therapy <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Hospice Care (\$5,000 lifetime maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Hospital Care <ul style="list-style-type: none"> • Outpatient services (surgery, laboratory and x-ray charges, surgery suite, and ambulatory surgical center) <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 Provider √ Non-Preferred Provider • Inpatient services (room and board and general nursing care, cardiac or intensive care units, ancillary services and supplies, and routine newborn care) <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	20% coinsurance 40% coinsurance \$100 copayment per visit, plus 20% coinsurance \$100 copayment per visit, plus 40% coinsurance 20% coinsurance 40% coinsurance
Human Growth Hormone Therapy (\$25,000 calendar year maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Laboratory Testing and X-ray Facilities <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Mammography Services <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Maternity Care (subject to a separate \$5,000 deductible) <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 40% coinsurance 20% coinsurance 40% coinsurance
Mental Health (\$1,500 calendar year maximum for inpatient and outpatient services combined) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	50% coinsurance 50% coinsurance

BENEFIT	AMOUNT YOU PAY
Non-Preferred Provider Services <ul style="list-style-type: none"> • Office, home, outpatient hospital visits, and surgical opinions • Office or outpatient hospital surgery, laboratory and x-ray charges, inpatient hospital visits, and routine newborn care 	\$20 copayment per visit, not subject to the deductible 40% coinsurance
Preferred Provider Services <ul style="list-style-type: none"> • Office, home, outpatient hospital visits, and surgical opinions • Office or outpatient hospital surgery, laboratory and x-ray charges, inpatient hospital visits, and routine newborn care 	\$20 copayment per visit, not subject to the deductible 20% coinsurance
Prescription Drugs (drugs limited to a 34 day supply; Mail-order program: one copayment/ coinsurance per 30 days supply, limited to 90 day supply) <ul style="list-style-type: none"> • Generic • Brand name prescription drugs (\$2,000 calendar year maximum) 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.	Not subject to the deductible \$10 copayment 50% coinsurance
Preventive Care <ul style="list-style-type: none"> • Routine physical examinations and outpatient well baby care • Immunizations • Routine laboratory and x-ray charges <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	Not subject to the deductible \$20 copayment per visit No coinsurance required 20% coinsurance 40% coinsurance
Rehabilitation <ul style="list-style-type: none"> • Inpatient services <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider • Outpatient services – including physical therapy, speech therapy, occupational therapy, and respiratory therapy (\$800 per calendar year maximum for each type of therapy) <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	20% coinsurance 40% coinsurance 20% coinsurance 40% coinsurance
Skilled Nursing Facility (30 days calendar year maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Temporomandibular Joint (TMJ) Disorders and Orthognathic Conditions (\$2,000 lifetime maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 40% coinsurance
Vision Services <ul style="list-style-type: none"> • Routine eye examination (one per calendar year maximum) • Vision hardware – frames, lenses, contacts (\$100 combined calendar year maximum) 	Not subject to the deductible No coinsurance required No coinsurance required

EXCLUSIONS

Benefits shall not be provided in any of the following circumstances or for any of the following conditions under the terms of this Policy:

- Any procedure, treatment, supply, or service not specifically listed as a Covered Service.
- 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. The only exception would be if the Insured is exempt from state or federal Workers' Compensation Law. See the Right of Reimbursement and Subrogation section of these General Provisions.
- 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; participation in a felony, riot or insurrection.
- Immunizations required for travel abroad, including but not limited to cholera, plague, typhoid, typhus, and yellow fever.
- 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.
- 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.
- Maternity benefits for Dependent children.
- Laetrile (amygdalin).
- 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, and charges for weight reduction programs.
- Heating pads, contour chairs, and therapeutic beds (not including certified, standard model hospital beds which will be paid under the Durable Medical Equipment section).
- Investigative treatment as determined by Regence BSI pursuant to the Definitions section of these General Provisions.
- 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 congenital disease or anomaly for an Insured Dependent 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.
- 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.

- Benefits which are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, 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.).
- Charge 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 this Policy, or (3) for which an Insured would have no legal obligation to pay in the absence of this or any similar coverage.
- Expense for services furnished by a Provider who is related to the Insured by blood or marriage or who resides in the Insured's household.
- Prescription drugs and medicines for smoking cessation.
- Charges for telephone or internet consultations; missed appointments; claim form completion; interest charges; legal services; obtaining medical records; setup and delivery of Durable Medical Equipment; or Provider travel and/or lodging expenses.
- 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 medication related to health care services which are not covered under this Policy. Notwithstanding this exclusion, Regence BSI may choose to cover certain over-the-counter medications when prescription drug benefits are provided under this 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.
- Elective abortions, except to preserve the life of the female Policyholder or spouse upon whom the abortion is performed.
- Services and supplies related to dentistry, dental implants, orthodontic treatment, or oral surgery whether necessary due to an accident, disease, deformity, or dental treatment, except as provided in this Policy.
- Orthodontic bracing for treatment of Temporomandibular Joint (TMJ) Disorders.
- 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.
- Diet and weight monitoring and educational services.
- Special foods, diets, vitamins, minerals, dietary and nutritional supplements, and nutritional therapy.
- Any medical or surgical procedures primarily for treatment of obesity that are intended to result in weight reduction, or for reversal, revision, or complications of surgery for obesity.

LIMITATIONS

- Total combined benefits paid for services of a Chiropractor, massage therapist, naturopath, or acupuncturist shall be limited to a combined maximum of \$500 per Insured each calendar year.
- Total Outpatient benefits paid for Physical Therapy shall be limited to a maximum of \$800 per Insured each calendar year.

- Total Outpatient benefits paid for Speech Therapy shall be limited to a maximum of \$800 per Insured each calendar year.
- Total Outpatient benefits paid for Occupational Therapy shall be limited to a maximum of \$800 per Insured each calendar year.
- Total Outpatient benefits paid for Respiratory Therapy shall be limited to a maximum of \$800 per Insured each calendar year.
- Total Inpatient and Outpatient benefits paid for the treatment of Mental or Neuropsychiatric Conditions shall be limited to a combined maximum of \$1,500 per Insured each calendar year.
- Total Inpatient and Outpatient benefits paid for the treatment of Chemical Dependency shall be limited to a combined maximum of \$1,500 per Insured each calendar year.
- Total benefits paid for the treatment of Temporomandibular Joint (TMJ) Disorders and orthognathic conditions shall be limited to a maximum of \$2,000 during an Insured's lifetime.
- Total benefits paid for covered human organ and tissue transplant and bone marrow reinfusion services shall be limited to a maximum of \$250,000 during an Insured's lifetime.
- Total benefits paid for home health care visits is limited to a maximum of \$5,000 per Insured each calendar year.
- Total benefits paid for hospice care services shall be limited to \$5,000 during an Insured's lifetime.
- Total benefits paid for diabetic education shall be limited to a maximum of \$400 per Insured each calendar year when education services are provided through a Regence BSI-approved diabetic education program.
- 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.
- Total benefits paid for human growth hormone therapy shall be limited to a maximum of \$25,000 per Insured each calendar year.
- Total benefits paid for brand name prescription drugs and brand name mail-order maintenance drugs shall be limited to a combined maximum of \$2,000 per Insured each calendar year.
- Total benefits paid for routine eye examinations shall be limited a maximum of one (1) examination per Insured each calendar year.
- Total benefits paid for vision hardware, including frames, lenses and contacts shall be limited to a combined maximum of \$100 per Insured each calendar year.
- Claims submitted to Regence BSI more than fifteen (15) 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.

Web Site Address: www.id.regence.com