



# Regence

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

## Protection Plus \$5,000 Deductible 2008 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 benefit booklet for a complete explanation of benefits, limitations, exclusions, and general provisions.

<b>Maximum Benefits</b>	\$1,000,000 during an Insured's lifetime each calendar year.
<b>Deductible</b>	\$5,000 per Insured each calendar year. No family shall be obligated to meet more than two (2) deductibles in the aggregate in any calendar year; however at least one (1) family member must meet his or her individual \$5,000 deductible. Benefits are payable after the deductible has been met.
<b>Human Organ and Tissue Transplants</b>	\$150,000 maximum during an Insured's lifetime.

BENEFIT	AMOUNT YOU PAY
<b>Alternative Medicine</b> (chiropractor, massage therapist, naturopath, dietitian, and acupuncturist)	
<ul style="list-style-type: none"> <li>• Participating Physician/Provider</li> <li>• Nonparticipating Physician/Provider</li> </ul>	No coinsurance required 20% coinsurance
<b>Ambulance Services</b> (prior review required for air ambulance)	No coinsurance required
<b>Blood or Blood Plasma</b>	No coinsurance required
<b>Chemical Dependency</b>	
<ul style="list-style-type: none"> <li>• Inpatient and outpatient services combined (\$10,000 during a period of 24 consecutive calendar months)               <ul style="list-style-type: none"> <li>√ Physician services                   <ul style="list-style-type: none"> <li>▪ Participating Physician/Provider</li> <li>▪ Nonparticipating Physician/Provider</li> </ul> </li> <li>√ Hospital services</li> </ul> </li> <li>• Medically necessary detoxification               <ul style="list-style-type: none"> <li>√ Physician services                   <ul style="list-style-type: none"> <li>▪ Participating Physician/Provider</li> <li>▪ Nonparticipating Physician/Provider</li> </ul> </li> <li>√ Hospital services</li> </ul> </li> </ul>	No coinsurance required 20% coinsurance No coinsurance required No coinsurance required No coinsurance required 20% coinsurance No coinsurance required
<b>Colorectal Screening</b> (including colonoscopy, sigmoidoscopy, fecal occult testing, or barium enemas)	
<ul style="list-style-type: none"> <li>• Participating Physician/Provider</li> <li>• Nonparticipating Physician/Provider</li> </ul>	No coinsurance required 20% coinsurance

BENEFIT	AMOUNT YOU PAY
<b>Contraceptives</b> (policyholder, spouse, and children) <ul style="list-style-type: none"> <li>• Oral contraceptive prescription drugs</li> <li>• Diaphragms and intrauterine devices, Injectable contraceptives (Depo Provera), and Norplant insertion <ul style="list-style-type: none"> <li>√ Participating Physician/Provider</li> <li>√ Nonparticipating Physician/Provider</li> </ul> </li> </ul>	<p>No coinsurance required</p> <p>No coinsurance required 20% coinsurance</p>
<b>Diabetic Supplies</b> (blood sugar diagnostics, lancets, swabs, urine test strips for blood glucose, injection aids, glucagon emergency kits, and insulin and syringes/needles)	<p>No coinsurance required</p>
<b>Durable Medical Equipment; Orthotics; and Prosthetic Devices</b>	<p>No coinsurance required</p>
<b>Home Health Care</b> (130 visits calendar year maximum)	<p>No coinsurance required</p>
<b>Hospice Care</b> (limited to a maximum of 6 months from the initial date covered care is provided)	<p>No coinsurance required</p>
<b>Hospital Care</b> <ul style="list-style-type: none"> <li>• Outpatient services (surgery, diagnostic laboratory and x-ray charges, surgery suite, and ambulatory surgical center)</li> <li>• Emergency room charge</li> <li>• Inpatient services (room and board and general nursing care, cardiac or intensive care units, and ancillary services and supplies)</li> </ul>	<p>No coinsurance required</p> <p>\$50 copayment per visit</p> <p>No coinsurance required</p>
<b>Injury to a Sound Natural Tooth</b> (12 months from date of accident)	<p>No coinsurance required</p>
<b>Maternity Care</b> (benefits are not provided for dependent children) <ul style="list-style-type: none"> <li>• Physician services (prenatal and delivery) <ul style="list-style-type: none"> <li>√ Participating Physician</li> <li>√ Nonparticipating Physician</li> </ul> </li> <li>• Hospital services (room and board and general nursing care)</li> </ul>	<p>No coinsurance required 20% coinsurance</p> <p>No coinsurance required</p>
<b>Mental Health</b> <ul style="list-style-type: none"> <li>• Outpatient services (\$500 calendar year maximum) <ul style="list-style-type: none"> <li>√ Physician services <ul style="list-style-type: none"> <li>▪ Participating Physician</li> <li>▪ Nonparticipating Physician</li> </ul> </li> <li>√ Hospital services</li> </ul> </li> <li>• Inpatient services (\$10,000 during a period of 24 consecutive calendar months; \$30,000 lifetime maximum) <ul style="list-style-type: none"> <li>√ Physician services <ul style="list-style-type: none"> <li>▪ Participating Physician</li> <li>▪ Nonparticipating Physician</li> </ul> </li> <li>√ Hospital services</li> </ul> </li> </ul>	<p>No coinsurance required 20% coinsurance</p> <p>No coinsurance required</p> <p>No coinsurance required 20% coinsurance</p> <p>No coinsurance required</p>
<b>Neurodevelopmental Therapy</b> (6 years of age and under) <ul style="list-style-type: none"> <li>• Physician services <ul style="list-style-type: none"> <li>√ Participating Physician</li> <li>√ Nonparticipating Physician</li> </ul> </li> <li>• Hospital services</li> </ul>	<p>No coinsurance required 20% coinsurance</p> <p>No coinsurance required</p>

BENEFIT	AMOUNT YOU PAY
<b>Newborn Care</b> <ul style="list-style-type: none"> <li>• Physician services <ul style="list-style-type: none"> <li>√ Participating Physician</li> <li>√ Nonparticipating Physician</li> </ul> </li> <li>• Hospital services</li> </ul>	No coinsurance required 20% coinsurance No coinsurance required
<b>Oxygen, Colostomy Supplies, and Allergy Antigens</b>	No coinsurance required
<b>Phenylketonuria Formulas (PKU)</b>	No coinsurance required
<b>Physician/Provider Services</b> <ul style="list-style-type: none"> <li>• Office, home, and outpatient/inpatient hospital visits, surgical services, and laboratory and x-ray charges <ul style="list-style-type: none"> <li>√ Participating Physician/Provider</li> <li>√ Nonparticipating Physician/Provider</li> </ul> </li> <li>• Prostate screening <ul style="list-style-type: none"> <li>√ Participating Physician</li> <li>√ Nonparticipating Physician</li> </ul> </li> <li>• Routine eye examination (one examination each 12 months) <ul style="list-style-type: none"> <li>√ Participating Physician</li> <li>√ Nonparticipating Physician</li> </ul> </li> </ul>	No coinsurance required 20% coinsurance No coinsurance required 20% coinsurance No coinsurance required 20% coinsurance
<b>Prescription Drugs</b>	No coinsurance required
<b>Rehabilitation</b> <ul style="list-style-type: none"> <li>• Inpatient services (\$15,000 calendar year maximum)</li> <li>• Outpatient services (\$1,000 calendar year maximum)</li> </ul>	No coinsurance required No coinsurance required
<b>Skilled Nursing Care</b> (30 day calendar year maximum)	No coinsurance required
<b>Temporomandibular Joint (TMJ) Disorders and Orthognathic Conditions</b> (\$2,000 lifetime maximum) <ul style="list-style-type: none"> <li>• Physician services <ul style="list-style-type: none"> <li>√ Participating Physician/Provider</li> <li>√ Nonparticipating Physician/Provider</li> </ul> </li> <li>• Hospital services</li> </ul>	No coinsurance required 20% coinsurance No coinsurance required
* Benefits are not subject to the deductible	

**Web Site Address:** [www.id.regence.com](http://www.id.regence.com)