



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

Regence HSA Healthplan 2.0SM Benefit Summary

The new Regence HSA Healthplan 2.0 is a simple way to pay for life's medical expenses. It's a comprehensive health plan and a tax-free savings account all rolled into one. You get broad medical coverage, support and guidance from an HSA specialist plus rewards for healthy living.

Lifetime Maximum Benefit	\$2,000,000
Calendar Year Deductible Applies to all covered expenses except where noted	Deductible: \$5,000 for single coverage \$10,000 for family coverage Family coverage: no one family member is eligible for benefits until the entire family deductible is met
Calendar Year Out-of-Pocket Maximum Out-of-pocket maximum amount per calendar year, including deductible, applies to all covered expenses. When the out-of-pocket maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year.	Individual out-of-pocket maximum: \$5,000 Family out-of-pocket maximum: \$10,000

Covered Services	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-Contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)
	Benefits will be provided at the percentage of the allowed amount as specified below, applied after deductible is met and until out-of-pocket maximum is reached.		
Professional Services Office and inpatient services and supplies			
Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies		100%	
Maternity (Subscriber and spouse)			
Preventive Care No benefit limits			
Immunizations - Adult and childhood No benefit limits			

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Covered Services	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-Contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)	
Benefits will be provided at the percentage of the allowed amount as specified below, applied after deductible is met and until out-of-pocket maximum is reached.				
Emergency Room Services				
Ambulance Services Air and ground ambulance to nearest facility				
Genetic Testing \$5,000 per lifetime maximum benefit (this limit does not apply to prenatal testing)				
Nutritional Counseling Three visits per lifetime (this limit does not apply to diabetic counseling)				
Durable Medical Equipment \$7,500 per calendar year maximum benefit (this limit does not apply to insulin pumps/supplies and lifesaving equipment such as oxygen and ventilators)				100%
Orthotics \$500 per calendar year maximum benefit (this limit does not apply to diabetic orthotics)				
Prostheses \$20,000 per calendar year maximum benefit (this limit does not apply to surgically implanted and external breast prostheses)				
Prescription Medication Coverage Retail or Mail Order: Up to 90 day supply for covered prescription medications (Up to 30 day supply for covered self-administrable injectable medications)				100%

Covered Services	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-Contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)
Benefits will be provided at the percentage of the allowed amount as specified below, applied after deductible is met and until out-of-pocket maximum is reached.			
Rehabilitation Services Inpatient: \$25,000 per calendar year maximum benefit Outpatient: \$1,500 per calendar year maximum benefit	100%		
Neurodevelopmental Therapy For children age 6 and under Inpatient and outpatient combined: \$1,500 per calendar year maximum benefit			
Home Health 130 visits per calendar year			
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime			
Skilled Nursing Facility 60 inpatient days per calendar year			
Temporomandibular Joint Disorders (TMJ) Treatment \$1,000 per calendar year maximum benefit			
Transplants Services and supplies to \$250,000 lifetime maximum benefit \$50,000 donor expense maximum benefit per transplant 6-month waiting period			

Covered Services	Optional Benefits Available (Optional benefits that are not elected are excluded from coverage)		
	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-Contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)
Chemical Dependency/Mental Health (Combined) Option 1 (Groups of 2-50): 8 inpatient days/12 outpatient visits per calendar year (subject to deductible and out-of-pocket maximum) Option 2 (All group sizes): No benefit maximums (subject to deductible and out-of-pocket maximum)		100%	
Vision One routine eye exam per calendar year Hardware limited to \$150 per calendar year maximum benefit Not subject to deductible			

Optional Program Available
Employee Assistance Program (EAP) No cost to the member for: Up to four face-to-face sessions per incident to manage stress or work-life balance situations Legal and financial assistance 24/7 crisis line

Additional Information	
Waiting Periods	No benefits are provided for treatment relating to a transplant until the member has been covered under this or a prior plan for six consecutive months. There is a twelve-month waiting period that must be met prior to benefits being available for pre-existing conditions. By pre-existing condition, we mean 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-month period before the enrollment date. Members may receive credit from prior medical coverage.
Outside the Service Area	Members have the security of knowing they can access Blue Cross and/or Blue Shield (Blue Plan) providers across the country and worldwide through the BlueCard® Program. Plan benefits apply as described above, and members may receive discounts on their services.

General Medical Exclusions

No benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, or for any direct complications or consequences thereof. However, these exclusions shall not apply with regard to an otherwise covered service for an injury, 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.

- **Complementary Care:** Including, but not limited to, the following: acupuncture, chiropractic care, massage or massage therapy and the services of an acupuncturist, a chiropractor, a massage therapist and a naturopath
- **Conditions Caused By Active Participation In a War or Insurrection:** The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection
- **Conditions Incurred In or Aggravated During Performances In the Uniformed Services:** The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of services in the uniformed services of the United States
- **Cosmetic/Reconstructive Services and Supplies** except to treat a congenital anomaly for members up to age 18, to restore a physical bodily function lost as a result of injury or illness or related to breast reconstruction following a medically necessary mastectomy, to the extent required by law
- **Counseling** in the absence of illness
- **Custodial Care:** Non-skilled care and helping with activities of daily living
- **Dental Services** provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of the teeth
- **Elective Abortion:** Termination of pregnancy (elective abortion), except when performed to preserve the life of the enrolled female member
- **Expenses Before Coverage Begins or After Coverage Ends:** Services and supplies incurred before your effective date under the contract or after your termination under the contract, except as may be provided under the other continuation options of the contract
- **Fees, Taxes, Interest:** Charges for shipping and handling, postage, interest, or finance charges that a provider might bill
- **Foot Care (Routine):** Routine foot care including treatment of corns and calluses and trimming of nails, except when indicated for diabetic patients
- **Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program
- **Growth Hormone Therapy** (coverage for these services may be provided under the prescription medication benefit)
- **Hearing Care:** Routine hearing examinations, programs or treatment for hearing loss including hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants
- **Infertility:** Treatment of infertility, except to the extent covered services are required to diagnose such condition including all assisted reproductive technologies and fertility drugs and medications
- **Investigational Services:** Treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures
- **Motor Vehicle Coverage and Other Insurance Liability:** Expenses that are payable under any automobile medical, personal injury protection ("PIP"), or automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the coordination of benefits provision of the plan shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance, whether or not you make a claim under such coverage. Once benefits under such contract or insurance are exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, we will provide benefits according to the plan.
- **Non-Direct Patient Care** including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges

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- **Obesity or Weight Reduction/Control:** Medical treatment, medication, surgical treatment (including reversals), programs, or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions
- **Orthognathic Surgery:** Services and supplies for orthognathic surgery. By "orthognathic surgery," we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from injury, congenital anomaly or abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to a temporomandibular joint disorder, injury, sleep apnea or congenital anomaly
- **Over the Counter Contraceptives** including supplies and oral contraceptives (coverage for these services may be provided under the prescription medications benefit)
- **Personal Comfort Items:** Items that are primarily for comfort, convenience, cosmetics, environmental control, or education
- **Physical Exercise Programs and Equipment** including hot tubs or membership fees at spas, health clubs, or other such facilities; applies even if the program, equipment, or membership is recommended by the member's provider
- **Private Duty Nursing** including ongoing shift care in the home
- **Reversal of Sterilizations** including services and supplies related to reversal of sterilization
- **Riot, Rebellion and Illegal Acts:** Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection, or rebellion or sustained by a member arising from an act deemed illegal by an officer or court of law
- **Self-Help, Self-Care, Training, or Instructional Programs** including diet and weight monitoring services, childbirth-related classes including infant care and breast feeding classes, instruction programs including those to learn how to stop smoking and programs that teach a person how to use durable medical equipment or how to care for a family member
- **Services and Supplies Provided by a Member of Your Family**
- **Services and Supplies That Are Not Medically Necessary**
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, or counseling services for sexual reassignment
- **Sexual Dysfunction:** Services and supplies including medications for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners when mental health services are covered benefits under the contract
- **Third-Party Liability:** Services and supplies for treatment of illness or injury for which a third party is or may be responsible
- **Tobacco Addiction Treatment**
- **Travel and Transportation Expenses** other than covered ambulance services
- **Vision Care:** Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversal or revisions of surgical procedures which alter the refractive character of the eye
- **Work-Related Conditions:** Expenses for services and supplies incurred as a result of any work-related injury or illness, including any claims that are resolved related to a disputed claim settlement. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law

General Pharmacy Exclusions

- **Acne Medication** for the treatment of acne in members over age 39
- **Certain Contraceptives:** Prescription contraceptives that cannot be self-administered, including Norplant, surgically inserted contraceptive devices, IUDs and Depo-Provera (coverage for these contraceptives may otherwise be provided under the medical benefit)
- **Cosmetic Purposes:** Prescription medications used for cosmetic purposes including removal, inhibition or stimulation of hair growth, retardation of aging or repair of sun-damaged skin
- **Devices or Appliances** (coverage for devices and appliances may otherwise be provided under the medical benefit)
- **Foreign Prescription Medications** except those associated with an emergency medical condition while you are traveling outside the United States, or those you purchase while residing outside the United States

- **Growth Hormones** unless we preauthorize them
- **Immunization Agents, Biological Sera, Blood, or Blood Plasma**
- **Inhibition and/or Suppression of Sleepiness:** Prescription medications used to inhibit and/or suppress drowsiness, sleepiness, tiredness or exhaustion, unless we preauthorize them
- **Insulin Pumps and Pump Administration Supplies** (coverage for insulin pumps and supplies is provided under the medical benefit)
- **Medications We Don't Consider Self-Administrable** (coverage for these medications may otherwise be provided under the medical benefit)
- **Nonprescription Medications:** Medications that by law do not require a prescription order
- **Off-Label Use Prescription Medications:** Prescription medications that have not yet received FDA approval for the purpose and in the manner they are being prescribed
- **Onychomycosis:** Prescription medications for the treatment of onychomycosis (nail fungus), unless we preauthorize them
- **Prescription Medications Dispensed in a Facility:** Prescription medications dispensed to you while you are a patient in a hospital, skilled nursing facility, nursing home or other health care institution
- **Prescription Medications Dispensed in Connection with Participation in a Clinical Trial**
- **Prescription Medications For Treatment of Infertility**
- **Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order**
- **Prescription Medications Not within a Provider's License:** Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license
- **Prescription Medications With No FDA Proven Therapeutic Indication**
- **Prescription Medications Without Examination:** Prescriptions made by a provider without recent and relevant in-person examination of the patient, whether the prescription order is provided by mail, telephone, internet or some other means
- **Professional Charges for Administration of Any Medication**

This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. For full coverage provisions, refer to the contract.

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