



An Independent Licensee of the Blue Cross and Blue Shield Association

REGENCE REVIVE

\$2,000 Deductible Limited Benefit Health Plan Benefit Summary

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. Please refer to your benefit booklet for a complete explanation of benefits, limitations, exclusions, and general provisions.

Maximum Benefits	\$2,000,000 during an Insured's lifetime.
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).
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.	

BENEFITS	AMOUNT YOU PAY
Ambulance Services (prior review required for air ambulance)	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
Blood and Blood Plasma	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
Contraceptives – available only when group has prescription drug coverage	
• Oral contraceptive prescription drugs *	Subject to prescription drug benefit
• Diaphragms and intrauterine devices	
√ Preferred Provider *	\$25 copayment per device
√ Non-Preferred Provider	50% coinsurance
• Injectable contraceptives (Depo Provera)	
√ Preferred Provider *	\$20 copayment per injection
√ Non-Preferred Provider	50% coinsurance
• Norplant insertion	
√ Preferred Provider *	\$100 copayment per implant
√ Non-Preferred Provider	50% coinsurance
Durable Medical Equipment (blood glucose monitors, insulin infusion devices, and insulin pumps; and lifesaving equipment such as ventilators and oxygen)	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance

BENEFITS	AMOUNT YOU PAY
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 Provider √ 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 • Routine newborn care – <i>available only when group has maternity coverage.</i> <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	20% coinsurance 50% coinsurance \$100 copayment per visit, plus 20% coinsurance \$100 copayment per visit, plus 50% coinsurance 20% coinsurance 50% coinsurance 20% coinsurance 50% coinsurance
Immunizations <ul style="list-style-type: none"> • Dependents up to age 18 • Adult immunizations <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	No coinsurance required, not subject to the deductible 20% coinsurance 50% coinsurance
Mammography Services (not subject to the outpatient laboratory and x-ray or preventive care calendar year maximums) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance
Maternity Care ** (benefits are not provided for dependent 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 (\$1,500 calendar year maximum. Mammography services are not subject to the calendar year maximum) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance
Phenylketonuria Formulas (PKU) <ul style="list-style-type: none"> • Preferred Provider • Non-Preferred Provider 	20% coinsurance 50% coinsurance

BENEFITS	AMOUNT YOU PAY
<p>Physician Services</p> <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 and surgeon fees <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider • Routine newborn care – <i>available only when group has maternity coverage.</i> <ul style="list-style-type: none"> √ Preferred Provider √ Non-Preferred Provider 	<p>\$25 copayment per visit, not subject to the deductible</p> <p>\$40 copayment per visit, not subject to the deductible</p> <p>20% coinsurance 50% coinsurance</p> <p>20% coinsurance 50% coinsurance</p>
<p>Prescription Drugs – three options a group can choose from</p> <p>Option 1</p> <p>Prescription Drugs * (34 day supply or 100-unit doses, whichever is less. Mail-order network only benefit: copayment per each 30 day supply, not to exceed a 90 day supply)</p> <ul style="list-style-type: none"> • Generic • Formulary brand name • Non-formulary brand name <p>Calendar year maximum for formulary and non-formulary: \$2,000 per insured</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>	<p>\$7 copayment 30% coinsurance 50% coinsurance</p>
<p>Option 2</p> <p>Prescription Drugs * (34 day supply or 100-unit doses, whichever is less. Mail-order network only benefit: copayment per each 30 day supply, not to exceed a 90 day supply)</p> <ul style="list-style-type: none"> • Generic <p>The following are subject to a \$5,000 deductible</p> <ul style="list-style-type: none"> • Formulary brand name • Non-formulary brand name <p>Out-of-pocket expense (\$3,500 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>	<p>\$5 copayment</p> <p>30% coinsurance 50% coinsurance</p>
<p>Option 3</p> <p>Prescription Drugs – Group chooses to not provide prescription drug coverage</p>	
<p>Preventive Care * (\$300 calendar year maximum)</p> <ul style="list-style-type: none"> • Routine physical examinations, outpatient well baby care, and routine gynecological examinations • Routine laboratory, x-ray charges, and mammography services <p>Note: Routine gynecological examinations, including but not limited to papanicolaou stain (pap smear) and mammography services shall not be subject to the \$300 calendar year maximum. Preventive care services are not subject to the Preferred and Non-Preferred Provider 4 office visit calendar year maximum.</p>	<p>\$25 copayment per visit</p> <p>No coinsurance required</p>

BENEFITS	AMOUNT YOU PAY
Prosthetic Devices (external and internal breast prostheses)	
• 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
* Benefits are not subject to the deductible	

** *Maternity care is optional and may not be included for groups with fewer than 10 employees*

Italics = watch for and/or remove these areas

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:

- 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 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.
- **Small Group Only:** Maternity and/or conditions due to pregnancy (including Involuntary Complications of Pregnancy), unless benefits are provided by an endorsement to the policy.
- **Small Group Only:** Routine newborn care, including nursery room charges, unless benefits are provided by an endorsement to the policy.
- Immunizations required for travel abroad, including but not limited to cholera, plague, typhoid, typhus, and yellow fever.
- 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, reduction mammoplasty, surgery for gynecomastia, 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); or

- ✓ Due to a congenital anomaly, disease, or accidental Injury.
- Investigative treatment as determined by Regence BSI pursuant to the definitions section of the General Provisions.
- 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 the schedule of benefits for preauthorized human organ and tissue transplants and bone marrow reinfusion.
- Benefits in connection with harvesting and reinfusion of bone marrow for the treatment of any illness, except as set forth in the preauthorized human organ and tissue transplants and bone marrow reinfusion.
- 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 schedule of benefits for preauthorized human organ and tissue transplants and bone marrow reinfusion.
- 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.
- Elective abortions, except to preserve the life of the female enrolled employee or spouse upon whom the abortion is performed.
- Services and supplies related to dentistry, temporomandibular joint (TMJ) disorders, dental implants, orthodontic treatment, oral surgery, 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.

Web Site Address: www.id.regence.com