Regence BlueShield of Idaho

An Independent Licensee of the Blue Cross and Blue Shield Association

REGENCE NOWSELECT
$1,000 Deductible Limited Health Plan
2006 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.

Maximum Benefits	$2,000,000 during an Insured's lifetime.
Deductible	$1,000 per Insured each calendar year. No family shall be obligated to meet more than $2,000 in the aggregate in any calendar year. Benefits are payable after the deductible has been met. Maternity Care: subject to a separate $5,000 deductible.
Out-of-Pocket Expense	$2,500 per Insured each calendar year (plus deductible). No family shall be obligated to meet more than $7,500 in the aggregate in any calendar year.
Human Organ and Tissue Transplants	$250,000 maximum during an Insured's lifetime.

BENEFIT	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
Diabetic Education ($400 calendar year maximum)	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
Hospital Care	
• Outpatient surgical services	
√ Preferred Provider	20% coinsurance
√ Non-Preferred Provider	50% coinsurance
• Emergency room charge (copayment is in addition to deductible and coinsurance)	
√ Preferred Provider	$100 copayment per visit, plus 20% coinsurance
√ Non-Preferred Provider	$100 copayment per visit, plus 50% coinsurance
• Inpatient services	
√ Preferred Provider	20% coinsurance
√ Non-Preferred Provider	50% coinsurance
Immunizations	
• Preferred Provider *	No coinsurance required
• Non-Preferred Provider	50% coinsurance

BENEFIT	AMOUNT YOU PAY
Mammography Services (not subject to the outpatient laboratory and x-ray calendar year maximum)	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
Maternity Care (subject to a separate $5,000 deductible)	
• Physician services (prenatal and delivery)	
√ Preferred Provider	20% coinsurance
√ Non-Preferred Provider	50% coinsurance
• Hospital services (room and board and general nursing care)	
√ Preferred Provider	20% coinsurance
√ Non-Preferred Provider	50% coinsurance
Non-Preferred Provider Services	
• Office, home, outpatient hospital visits, and 2nd and 3rd surgical opinions (6 visits per calendar year combined with Preferred Provider services)	$25 copayment per visit, not subject to the deductible
• Inpatient hospital visits, surgeon fees, and routine newborn care	50% coinsurance
Outpatient Laboratory and X-ray Services ($2,500 calendar year maximum. Mammography services are not subject to the calendar year maximum)	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
Preferred Provider Services	
• Office, home, outpatient hospital visits, and 2nd and 3rd surgical opinions (6 visits per calendar year combined with Non-Preferred Provider services)	$25 copayment per visit, not subject to the deductible
• Inpatient hospital visits, surgeon fees, and routine newborn care	20% coinsurance
Prescription Drugs, Mail-Order Program, and Oral Contraceptives * (per each 34 day supply. Mail-order program: one copayment per 30-day supply, limited to 90-day supply.)	
• Pharmacy, mail-order program, and oral contraceptives	
√ Generic	$10 copayment
√ Brand name ($1,200 calendar year maximum)	50% coinsurance
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.	
Preventive Care * ($300 calendar year maximum)	
• Routine physical examinations, outpatient well baby care, and routine gynecological examinations	$25 copayment per visit
• Routine laboratory and x-ray charges	No coinsurance required
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.	
Skilled Nursing Facility (30 days calendar year maximum)	
• Preferred Provider	20% coinsurance
• Non-Preferred Provider	50% coinsurance
* Benefits are not subject to the deductible	

EXCLUSIONS

Benefits shall not be provided for any procedure, treatment, supply, or service not specifically listed as a Covered Services, or in any of the following circumstances or for any of the following conditions under the terms of this Policy, including direct or indirect complications:

- Any Preexisting Condition or disease, except for congenital anomalies of an Insured Dependent child.
- To the extent benefits are provided or covered by Medicare or any other governmental agency, except as otherwise provided by law (for example, Medicaid).
- Any Injury or Illness resulting from (1) any war or act of war (whether declared or undeclared); (2) participation in a felony, riot or insurrections; or (3) service in the armed forces or units auxiliary to it.
- Any Illness, treatment or medical condition arising out of aviation.
- Any situation in which no specific medical treatment plan is furnished, including rest cures and Custodial Care.
- Charges for transportation, except for ambulance services specifically covered in this Policy.
- Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column (chiropractic services).
- Hospice care, home health care, and/or home infusion therapy.
- Speech Therapy, Rehabilitation/Occupational Therapy, respiratory therapy, and Physical Therapy.
- Birth control intrauterine devices and diaphragms, contraceptive implants, and injectable contraceptives (Depo Provera, etc.), regardless of intended use.
- Acupuncture.
- Routine eye examinations, eye glasses; visual therapy or training, and radial keratotomy (refractive keratoplasty or other surgical procedures to correct refractive errors/ astigmatism).
- Routine hearing examinations; hearing aids.
- 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.
- Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
- Supplies, except when inclusive of a hospitalization, Skilled Nursing Facility admission or covered Surgery. This exclusion includes diabetic supplies such as blood sugar diagnostics, lancets, swabs, and urine test strips, and insulin syringes/needles.
- Durable medical equipment, whether rental or purchase and regardless of intended use.

- Orthotic devices.
- Prosthetic devices.
- Any medical, prescription drug, or time loss benefits for any Injury or Illness, if the costs associated with the Injury or Illness may be recoverable from a third party or through worker's compensation or from any other source (refer to the Right of Reimbursement and Subrogation provision for additional information).
- Human Growth Hormone therapy.
- 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; and (4) Assisted Reproductive Technology (ART) procedures.
- Services and supplies (including prescription drugs and medications) for the treatment of Mental or Nervous Disorders, alcoholism and drug addiction.
- Charges for services and supplies 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 a member of the Insured's Immediate Family. For the purposes of this exclusion, "Immediate Family" means any person who is related to the Insured by blood or marriage or who resides in the Insured's household.
- Charges for non-medical care such as telephone or internet consultations; missed appointments; claim form completion; interest charges; legal services; and obtaining medical records.
- Dental care or treatment, including services and supplies related to orthodontic treatment, oral Surgery, treatment of Temporomandibular Joint (TMJ) Disorders, and Orthognathic Surgery.
- Services related to the treatment of weight, including diet and weight monitoring; educational services; medical or surgical procedures that are intended to result in weight reduction, or for reversal, revision, or complications of such Surgery.
- Special foods, diets, vitamins, minerals, dietary and nutritional supplements, and nutritional therapy.

Web Site Address: www.id.regence.com