

Regence Innova[®] Medical Plan

\$30/\$45 Copay

\$1,000 Deductible

90%/70%/70% Coinsurance

NORTH IDAHO COLLEGE

Effective Date: July 1, 2010



Regence

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

Benefit Summary

Lifetime maximum benefit	\$2,000,000
Deductible per plan year	\$1,000 Per Member \$2,000 Per Family (2 times the member amount)
Maximum coinsurance per plan year	\$3,000 Per Member \$6,000 Per Family (2 times the member amount)
After the maximum coinsurance is met, the plan pays	100% for the remainder of the plan year except where noted

Understanding Your Benefits

- Your plan features **Upfront Benefits**. Each office visit is not subject to the deductible for Category 1 and 2 only. In addition, the first \$800 of outpatient laboratory and radiology services per plan year are not subject to the deductible.
- We will begin to pay benefits for other covered services in any plan year only after your deductible is satisfied. Your deductible applies for all services unless otherwise specified. Copayments do not count toward the deductible.
- Once you have satisfied any applicable deductible and any applicable copayment, we pay a percentage of the allowed amount for covered services. When our payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Member Responsibility).

You Select Your Provider and Control Your Out-of-Pocket Expenses

- Category 1.** You choose to see a preferred provider and save the most in your out-of-pocket expenses. Choosing this category means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. You can find a list of providers at our Website or by calling Customer Service.
- Category 2.** You choose to see a participating provider and your out-of-pocket expenses will generally be higher than if you choose Category 1 because we may negotiate larger discounts with preferred providers that will result in lower out-of-pocket amounts for you. Choosing this category means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services.
- Category 3.** You choose to see a provider that does not have a participating contract with us and your out-of-pocket expenses will generally be higher than Category 1. **Also, choosing this category means you may be billed for balances beyond any deductible, copayment, and/or coinsurance.** This is sometimes referred to as balance billing.

Covered Medical Services (Per Member)	Member Responsibility Category 1	Member Responsibility Category 2	Member Responsibility Category 3
Office Visits (Upfront Benefit) <ul style="list-style-type: none"> Each office visit For illness or injury 	\$30 copay (deductible waived)	\$45 copay (deductible waived)	30%
Outpatient Laboratory and Radiology Services (Upfront Benefit) <ul style="list-style-type: none"> The first \$800 per plan year For illness, injury or preventive care 	0% (deductible waived)	0% (deductible waived)	0% (deductible waived)
Expanded Office Services (Upfront Benefit) <ul style="list-style-type: none"> Medical services, surgical procedures, and therapeutic injections performed in the office, and laboratory and radiology services For illness or injury 	10% (deductible waived)	30% (deductible waived)	30% (deductible waived)

NORTH IDAHO COLLEGE 7/2010

Covered Medical Services (Per Member)	Member Responsibility Category 1	Member Responsibility Category 2	Member Responsibility Category 3
After the Upfront Benefits are Exhausted <ul style="list-style-type: none"> ▪ Laboratory and radiology services ▪ For illness or injury 	10%	30%	30%
Professional Services <ul style="list-style-type: none"> ▪ Unless otherwise provided under the upfront benefits and expanded office services ▪ Medical services, office visits, inpatient visits, radiology and laboratory services, diagnostic procedures and surgical services 	10%	30%	30%
Preventive Services <ul style="list-style-type: none"> ▪ Routine office visits including well-baby care and routine physical exams. ▪ Routine laboratory, radiology and diagnostic procedures including mammography and prostate screenings ▪ Routine procedures including routine colonoscopies ▪ Immunizations for adults and children 	0% (deductible waived)	0% (deductible waived)	0% (deductible waived)
Ambulance Services	10%	10%	10%
Blood Bank	10%	10%	10%
Complementary Care <ul style="list-style-type: none"> ▪ Acupuncturists, Chiropractors and Naturopaths ▪ \$1,000 per plan year maximum benefit ▪ Does not apply toward maximum coinsurance 	10% (deductible waived)	10% (deductible waived)	10% (deductible waived)
Durable Medical Equipment <ul style="list-style-type: none"> ▪ \$7,500 per plan year maximum benefit 	10%	30%	30%
Emergency Room (Including Professional Charges) <ul style="list-style-type: none"> ▪ Copay waived if admitted directly to a hospital or facility on an inpatient basis 	10% after \$75 copay	10% after \$75 copay	10% after \$75 copay
Genetic Testing <ul style="list-style-type: none"> ▪ \$5,000 per member lifetime maximum benefit 	10%	30%	30%
Home Health Care <ul style="list-style-type: none"> ▪ 130 visit limit per plan year 	10%	30%	30%
Hospice Care <ul style="list-style-type: none"> ▪ 14 respite care day limit per member lifetime 	10%	30%	30%
Hospital Care <ul style="list-style-type: none"> ▪ Inpatient, Outpatient and Ambulatory Service Facility 	10%	30%	30%
Maternity Care	10%	30%	30%
Mental Health/Chemical Dependency Services	10%	30%	30%
Neurodevelopmental Therapy <ul style="list-style-type: none"> ▪ Covered for children age 6 and under ▪ \$1,500 per plan year maximum benefit 	10%	30%	30%
Nutritional Counseling <ul style="list-style-type: none"> ▪ 3 visit limit per member lifetime 	10%	30%	30%
Orthotic Devices <ul style="list-style-type: none"> ▪ \$500 per plan year maximum benefit 	10%	30%	30%
Prosthetic Devices <ul style="list-style-type: none"> ▪ \$32,000 per plan year maximum benefit 	10%	30%	30%

Covered Medical Services (Per Member)	Member Responsibility Category 1	Member Responsibility Category 2	Member Responsibility Category 3
Rehabilitation Services <ul style="list-style-type: none"> ▪ Inpatient: \$50,000 per plan year maximum benefit ▪ Outpatient: \$5,000 per plan year maximum benefit 	10%	30%	30%
Routine Hearing Examinations	20% (deductible waived)	20% (deductible waived)	20% (deductible waived)
Skilled Nursing Facility (SNF) Care <ul style="list-style-type: none"> ▪ 120 inpatient day limit per plan year 	10%	30%	30%
Temporomandibular Joint (TMJ) Disorders <ul style="list-style-type: none"> ▪ \$1,000 per plan year maximum benefit 	10%	30%	30%
Transplants <ul style="list-style-type: none"> ▪ \$250,000 limit per member lifetime ▪ \$50,000 limit for donor expenses per transplant ▪ 6 month waiting period (you may receive credit from your prior medical coverage) 	10%	30%	30%

Prescription Medication Benefits

A nationwide network of Participating Pharmacies is available to you. Pharmacies that participate in this network submit claims electronically. You can find a list of Participating Pharmacies at our Website, www.myRegence.com.

Individual deductible per plan year

N/A

Individual maximum coinsurance per plan year

\$4,000 (calculated separately from your medical maximum coinsurance)

Covered Prescription Medication Services (Per Member)	Member Responsibility Generic	Member Responsibility Formulary Brands	Member Responsibility Non-Formulary Brands
Prescription Medications from a Pharmacy <ul style="list-style-type: none"> ▪ 30-day supply for each prescription 	\$5	\$25	\$55
Injectable Medications from a Pharmacy or Mail-Order Supplier <ul style="list-style-type: none"> ▪ 30-day supply for each injectable medication 	\$5	\$25	\$55
Maintenance Medications from a Mail-Order Supplier <ul style="list-style-type: none"> ▪ 90-day supply for each prescription 	\$10	\$50	\$110
Brand-Name Prescription Medication Instead Of Generic: If an equivalent generic medication is available and a brand-name medication is chosen, the member is responsible for paying the applicable brand-name co-payment/co-insurance plus the difference in price between the equivalent generic medication and the brand-name medication not to exceed total retail cost.			

BlueCard[®] Program (Out of Area or Travel)

The BlueCard Program is a unique program that enables you to access hospitals and physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at www.bcbs.com or call 1 (800) 810-BLUE (2583).

General Exclusions

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise covered service for an injury, if 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.

Preexisting Condition Exclusion

Exclusion Period for Preexisting Conditions	12 months (you may receive credit from your prior medical coverage)
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Important note: By preexisting 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 6-month period before the enrollment date.

Creditable coverage means with respect to an individual, health benefits or coverage provided under any of the following: Group health benefit plan; Health insurance coverage without regard to whether the coverage is offered in the group market, individual market or otherwise; Medicare; Medicaid; medical and dental care for members and certain former members of the uniformed services and their dependents ("uniformed services" means the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Public Health Service); a medical care program of the Indian Health Services or of a tribal organization; a state high-risk pool coverage; Federal Employees Health Benefits Program (FEHBP); a public health plan (a plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage to individuals enrolled in the plan); or a health plan issued under the Peace Corps Act. A state Children's Health Insurance Program (CHIP), is creditable coverage, whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

Medical Exclusions

Condition 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.

Condition 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 service 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 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 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 except as specifically provided under the routine hearing examinations benefit of the contract, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, 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: Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures.

Medical Exclusions

Mental Health Treatment For Certain Conditions including diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders for all ages (these diagnosis codes include sexual disorders, such as sexual dysfunctions not caused by a medical condition, paraphilias, and gender identity disorders). Additionally, we will not cover any "V code" diagnoses except the following when medically necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger.

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.

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: By orthognathic surgery, we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from 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 medication 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.

Reversals of Sterilizations including services and supplies related to reversals 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 directly from an act deemed illegal by an officer or a 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 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.

Sexual Reassignment Treatment and Surgery: Treatment, surgery or counseling services for sexual reassignment.

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 including supportive items for addiction to tobacco, tobacco products or nicotine substitutes.

Travel and Transportation Expenses other than covered ambulance services.

Vision Care: Routine eye exam and vision hardware. 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.

Prescription Medication 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.

Prescription Medication Exclusions

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 Smoking Cessation
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

Please note: This benefit summary provides a brief description of your health care plan benefits, limitations and exclusions under your health care plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at our Website, www.myRegence.com. Please refer to your benefits booklet for a complete list of benefits, the limitations and exclusions that apply, and a definition of medical necessity.



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Contact Customer Service at 1 (888) 367-2117

www.regence.com