Nez Perce County
Regence BlueShield of Idaho, Inc.
Classic℠ Medical Plan 1

Effective Date: October 1, 2018

Medical Benefit Summary		
	Member Responsibility In-Network Provider	***Member Responsibility Out-of-Network Provider***
Coinsurance	20%	40%
Deductible per Calendar Year	$1,500 Member/$3,000 Family	$1,500 Member/$3,000 Family
Out-of-Pocket Maximum per Calendar Year	$4,500 Member /$9,000 Family	$4,500 Member /$9,000 Family

Be aware that your actual costs for Covered Services provided by an Out-of-Network Provider may exceed the Out-of-Pocket Maximum amount. In addition, Out-of-Network Providers can bill you for the difference between the amount charged and our allowed amount and that amount does not count toward any Out-of-Pocket Maximum.

Core Medical Services (Per Member) Unless Otherwise Noted, a Deductible Applies		
	Member Responsibility In-Network Provider	***Member Responsibility Out-of-Network Provider***
Office Visits For illness or injury All other services	20% 20% (deductible waived)	40% 40%
Preventive Care Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA).	0% (deductible waived)	40%

Additional Medical Services (Per Member) Unless Otherwise Noted, a Deductible Applies		
	Member Responsibility In-Network Provider	***Member Responsibility Out-of-Network Provider***
Ambulance Services	20%	
Ambulatory Surgical Center	10%	40%
Blood Bank	20%	
Dental Hospitalization	20%	40%
Detoxification	20%	
Diabetic Education	20%	40%
Durable Medical Equipment	20%	40%
Emergency Room (Including Professional Charges) Copay applies to the facility charge, whether or not the deductible has been met. Copay waived if admitted directly to a hospital or facility on an inpatient basis.	20% after $150 copay	
Family Planning	20%	40%
Genetic Testing	20%	40%
Home Health Care Limit: 130 visits per Calendar Year	20%	40%
Hospice Care Limit: 14 inpatient or outpatient respite care days per Member Lifetime	20%	40%
Hospital Care Inpatient and Outpatient	20%	40%
Maternity Care Maternity services for children are not covered	20%	40%
Medical Foods (PKU)	20%	40%

Additional Medical Services (Per Member) Unless Otherwise Noted, a Deductible Applies		
	Member Responsibility In-Network Provider	***Member Responsibility Out-of-Network Provider***
Mental Health/ Substance Use Disorder – Inpatient Services	20%	40%
Mental Health/ Substance Use Disorder – Outpatient Office/Psychotherapy Services	100% (deductible waived)	40%
Mental Health/ Substance Use Disorder – Outpatient Therapy Services	100% (deductible waived)	40%
Neurodevelopmental Therapy Covered for children age 6 and under Inpatient: Unlimited Outpatient: 28 visits per Calendar Year	20%	40%
Newborn Care	20%	40%
Nutritional Counseling Limit: 3 visits per Lifetime (diabetic education and counseling is not subject to this limit)	20%	40%
Orthotic Devices	20%	40%
Outpatient Radiology & Lab	20%	40%
Palliative Care Limit: 30 visits per Calendar Year for counseling and home health	20%	40%
Prosthetic Devices	20%	40%
Rehabilitation Services Inpatient Limit: 44 days per Calendar Year Outpatient Limit: 52 visits per Calendar Year	20%	40%

Additional Medical Services (Per Member) Unless Otherwise Noted, a Deductible Applies		
	Member Responsibility In-Network Provider	***Member Responsibility Out-of-Network Provider***
Skilled Nursing Facility (SNF) Care Limit: 60 inpatient days per Calendar Year	20%	40%
Spinal Manipulations Limit: 20 Visits per Calendar Year	20%	40%
Telemedicine	20%	40%
Temporomandibular Joint (TMJ) Disorder	20%	40%
Therapeutic Injections	20%	40%
Transplants	20%	40%

Prescription Benefit Summary	
Individual Deductible per Calendar Year	Not Applicable
Individual Out-of-Pocket Maximum per Calendar Year	Shared with Medical

Covered Prescription Medication Services (Per Member)			
	Member Responsibility Generic Preferred & Non-Preferred	***Member Responsibility Preferred Brands***	***Member Responsibility Non-Preferred Brands***
Prescription Medications From a Pharmacy 90-day supply for each prescription	$10 copay per 30-day supply	$35 copay per 30-day supply	$60 copay per 30-day supply
Injectable Medications From a Pharmacy or Mail-Order Supplier 30-day supply for each injectable medication	$10 copay per 30-day supply	$35 copay per 30-day supply	$60 copay per 30-day supply
Medications From a Mail-Order Supplier 90-day supply for each prescription	$30 copay per 90-day supply	$105 copay per 90-day supply	$180 copay per 90-day supply

Prescription Medications from a Specialty Pharmacy 30-day supply for each specialty medication	**Participating:** $150 copay preferred / non-preferred retail prescription**]** **Non-Participating:** 40% preferred / non-preferred retail prescription
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 copayment/co-insurance plus the difference in price between the equivalent generic medication and the brand-name medication not to exceed total retail cost.	

General Medical 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: 1) 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; or 2) a preventive service as specified under the Preventive Care and Immunizations benefit.

Activity Therapy: Creative arts, play, dance, aroma, music, equine or other animal-assisted, recreational or similar therapy; sensory movement groups; and wilderness or adventure programs.

Acupuncture

Applied Behavior Analysis (ABA) Therapy

Assisted Reproductive Technologies: we do not cover any assisted reproductive technologies (including, but not limited to, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstances.

Certain Therapy, Counseling and Training: Educational, vocational, social, image, milieu or marathon group therapy, premarital or marital counseling, Employee Assistance Program (EAP) services, except as provided under the EAP Section, if applicable; job skills or sensitivity training.

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.

Contraceptive Methods: Any contraceptive method (including, but not limited to, drugs, devices, supplies and sterilization procedures) and associated patient education and counseling for women with reproductive capacity.

Cosmetic/Reconstructive Services and Supplies: Cosmetic and/or reconstructive services and supplies, except in the treatment of the following: to treat a congenital anomaly for members up to age 26; 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 Except as required by law, We do not cover counseling in the absence of Illness.

Custodial Care: Except as provided under the Palliative Care benefit, We do not cover non-skilled care and helping with activities of daily living.

Dental Services: We do not cover 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: Except when performed to preserve the life of the enrolled female member, we do not cover termination of pregnancy (elective abortion).

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.

Family Counseling: Except when family counseling is part of the treatment for a child or adolescent with a covered diagnosis, We do not cover family counseling.

Fees, Taxes, Interest: Charges for shipping and handling, postage, interest, or finance charges that a provider might bill. We also do not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Government Programs: Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the service area (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Growth Hormone Therapy: Except as provided under the Prescription Medication Benefits, We do not cover growth hormone therapy.

Hearing Aids and Other Devices: Except for cochlear implants, We do not cover hearing aids (externally work or surgically implanted) or other hearing devices.

Hypnotherapy and Hypnosis Services: Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, Mental Health Conditions, Substance Use Disorders or for anesthesia purposes.

Illegal Services, Substances and Supplies: Services, substances and supplies that are illegal as defined under state or federal law.

Individualized Education Program (IEP): Services or supplies, including, but not limited to, supplementary aids and supports as provided under an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility: Except as provided under the Infertility Treatment benefit or to the extent Covered Services are required to diagnose such condition, We do not cover treatment of infertility, including, but not limited to, surgery, fertility drugs and medications.

Investigational Services: Except as provided under the Approved Clinical Trials benefit, We do not cover Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol.

Motor Vehicle Coverage and Other Available Insurance: Expenses for services and supplies 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 shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Member, whether or not the Member makes a claim under such coverage. Further, the Member is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. 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.

Non-Direct Patient Care: Services that are not direct patient care, including: appointments scheduled and not kept (missed appointments); charges for preparing or duplicating medical reports and chart notes; itemized bills or claim forms (even at Our request); and visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as provided under the Telehealth and Telemedicine benefit**{**s**}**.

Obesity or Weight Reduction/Control: Except as provided under the Nutritional Counseling benefit or as required by law, We do not cover medical treatment, medications, surgical treatment (including treatment of complications, revisions and reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery: Except for orthognathic surgery due to an Injury, temporomandibular joint disorder, sleep apnea or Congenital Anomaly, We do not cover 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 abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Over-the-Counter Contraceptives: Except as provided under the Prescription Medication Benefits section or as required by law, We do not cover over-the-counter contraceptive supplies.

Personal Comfort Items: Items that are primarily for comfort, convenience, cosmetics, environmental control, or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes and therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment: Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion 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: 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.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training, or Instructional Programs: Self-help, non-medical self-care and training programs, including: childbirth-related classes including infant care; and instruction programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member. This exclusion does not apply to services for training or educating a Member when provided without separate charge in connection with Covered Services or when specifically indicated as a covered service (for example, nutritional counseling, diabetic education and teaching doses for Self-Administrable Injectable Medications).

Services and Supplies Provided by a Member of Your Family: Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means: You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings; Your spouse's or domestic partner's parents' spouses or domestic partners, siblings and half-siblings; Your child's or stepchild's spouse or domestic partner; and any other of Your relatives by blood or marriage or who shares a residence with You.

Services and Supplies That Are Not Medically Necessary: Except for preventive care benefits provided, We do not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction: Except for covered Mental Health Services when Mental Health Services are covered benefits, We do not cover treatment, services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Third-Party Liability: Services and supplies for treatment of illness or injury for which a third party is or may be responsible.

Travel and Transportation Expenses other than covered ambulance services

Travel Immunizations for purposes of travel, occupation or residency in a foreign country. **Varicose Vein Treatment:** Except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins, We do not cover treatment of varicose veins.

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. We may require the Member to file a claim for workers' compensation benefits before providing any benefits under this coverage. We do not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if Member is exempt from state or federal workers' compensation law.

General Pharmacy Exclusions

Biological Sera, Blood, or Blood Plasma

Cosmetic Purposes: Prescription medications used for cosmetic purposes including, but not limited to: removal, inhibition or stimulation of hair growth; anti-aging; repair of sun-damaged skin or reduction of redness associated with rosacea.

Devices or Appliances: Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided).

Foreign Prescription Medications: Except for Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States, or Prescription Medications You purchase while residing outside the United States, We do not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.

Insulin Pumps and Pump Administration Supplies: Coverage for insulin pumps and supplies is provided under the medical benefits.

Medications We Don't Consider Self-Administrable: Coverage for these medications may otherwise be provided under the medical benefits.

Nonprescription Medications: Except for medications included on Our Formulary, approved by the FDA or a Prescription Order by a Physician or Practitioner, We do not cover medications that by law do not require a Prescription Order, for example, over-the-counter medications, including vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements.

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. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.

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 Lower Cost Alternatives: Except for higher cost Prescription Medications that are Medically Necessary, We do not cover Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives.

Prescription Medications Without Examination: Except as provided under the Telehealth and Telemedicine benefits, We do not cover 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. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe: 1) an opioid antagonist to a Member who is at risk of experiencing an opiate-related overdose; or 2) an epinephrine auto-injector to a Member who is at risk of experiencing anaphylaxis.

Professional Charges for Administration of Any Medication

Please note: This benefit summary provides a brief description or illustration of your health care plan benefits, limitations and/or 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.Regence.com**. Please refer to your benefits booklet or Summary Plan Description for a complete list of benefits, the limitations and/or exclusions that apply, and a definition of medical necessity. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

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