



Regence BlueCross BlueShield of Utah 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: \$3,000 for single coverage, \$5,000 or \$7,000 for family coverage. Benefits begin for one family member when the single deductible is met. When the family deductible is met, benefits begin for the entire family.
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)
	(ValueCare) or (BlueOption)		
	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	80%	60%	60%
Hospital Services/Ambulatory Surgical Center			
Maternity			
Preventive Care No benefit limits Not subject to deductible			
Immunizations - Adult and childhood No benefit limits Not subject to deductible			

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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	80%	80%	80%
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)			
Orthotics \$500 per calendar year maximum benefit (this limit does not apply to diabetic orthotics)			
Prostheses \$20,000 per calendar year maximum benefit (this does not apply to surgically implanted and external breast prosthesis)			
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)	80% Member may be balance billed when a nonparticipating pharmacy is used.		

Covered Services	Category 1 Preferred (ValueCare) or (BlueOption)	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	80%	60%	60%
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			
Spinal Manipulations 10 spinal manipulations per calendar year			
Temporomandibular Joint Disorders (TMJ) Treatment \$1,000 per calendar year maximum benefit			
Transplants \$250,000 lifetime maximum benefit; \$500,000 lifetime maximum benefit when received from a Blue Distinction Center [®] of Excellence as authorized \$50,000 donor expense maximum benefit per transplant 12-month waiting period			

Covered Services	Optional Benefits Available (Optional benefits that are not elected are excluded from coverage)		
	Category 1 Preferred (ValueCare) or (BlueOption)	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 (Groups of 2-50): No benefit maximums (subject to deductible and out-of-pocket maximum) (Groups of 51+): No benefit maximums (subject to deductible and out-of-pocket maximum)	50%		
	80%	60%	60%
Spinal Manipulations Option with no benefit maximum	80%	60%	60%
Vision One routine eye exam per calendar year Hardware limited to \$150 per calendar year maximum benefit Not subject to deductible	100%		

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 twelve consecutive months. There is a nine-month waiting period that must be met prior to benefits being available for pre-existing conditions. 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
Coverage is not provided for any of the following, including direct complications or consequences that arise from:
<ul style="list-style-type: none"> • Cosmetic/Reconstructive Services and Supplies except for reconstruction for functional injury and disease, to treat a congenital anomaly for members up to age 18, and for 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 Examinations and Treatments • Fees, Taxes, Interest: Charges for shipping and handling, postage, interest, or finance charges that a provider might bill • Government Programs: Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program • Infertility except to the extent covered services are required to diagnose such condition • Investigational Services: Treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures • Medications without a Prescription Order • Military Service Related Conditions: The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection or conditions incurred in or aggravated during performance in the Uniformed Services • Motor Vehicle Coverage and Other Insurance Liability • 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 • Orthognathic Surgery except for congenital conditions, temporomandibular joint disorder, injury, and sleep apnea

General Medical Exclusions

Coverage is not provided for any of the following, including direct complications or consequences that arise from:

- **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
- **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, sustained by a member while committing an illegal act or felony
- **Routine Foot Care** including treatment of corns and calluses and trimming of nails
- **Routine 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, except for cochlear implants
- **Self-Help, Self-Care, Training, or Instructional Programs** including childbirth classes, diet and weight monitoring services and 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**
- **Services to Alter Refractive Character of the Eye**
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, or counseling services for sexual reassignment
- **Sexual Dysfunction:** Regardless of cause, except for counseling provided by covered, licensed mental health practitioners, if chemical dependency/mental health benefit coverage is selected
- **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
- **Work-Related Conditions** except for subscribers who are owners, partners, or corporate officers and are exempt from state or federal workers' compensation law

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.