

Individual Direct Bronze HSA Plan Benefit Highlights

1/1/14



Plan Features

- **Provider Choice:** For In-Network benefits, members have direct access to their choice of providers within the Preferred network. Member coinsurance levels are lowest for In-Network providers. If a member chooses an Out-of-Network provider, the member may be required to pay costs above the allowed amount.

Calendar Year Deductible

- Separate deductible amounts per calendar year for In-Network / Out-of-Network providers.
- Applies to all covered expenses except where noted

Single
\$5,000/\$10,000

Family
\$10,000/\$20,000

Calendar Year Out-of-Pocket Maximums

- Separate out-of-pocket maximum amounts for In-Network/Out-of-Network providers
- Applies to all covered expenses except where noted
- 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

Single
\$6,250/\$12,500

Family
\$12,500/\$25,000

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Covered Services

- Member responsibility for In-Network services is indicated below, after In-Network deductible is met and until out-of-pocket maximum is met, except where noted.
- Out-of-Network services are covered 50% after Out-of-Network deductible is met and until out-of-pocket maximum is met, except where noted.

Preventive Care and Immunizations In-Network not subject to deductible	0%
Office Visits	30%
Chemical Dependency Treatment / Mental Health (Inpatient and Outpatient)	30%
Emergency Room Services In-Network deductible, coinsurance and In-Network out-of-pocket maximum apply regardless of provider network.	30%
Hospital Services Inpatient and outpatient services and supplies	30%
Home Health	30%
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime	30%
Radiology and Lab (Inpatient and Outpatient)	30%
Rehabilitation Services (Inpatient and Outpatient) Inpatient: No limit Outpatient: 20 visits per calendar year	30%
Skilled Nursing Facility 30 days per calendar year	30%
Services of a Chiropractor 12 visits per calendar year	30%

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Prescription Medications

Deductible (per calendar year) In-Network medical deductible applies unless otherwise specified	Deductible applies
Tier 1: Generics (Category 1)	25% Retail/20% Mail
Tier 2: Generics (Category 2) and Brand Name (Category 1)	35% Retail/30% Mail
Tier 3: Brand Name (Category 2)	50% Retail/40% Mail
Tier 4: Specialty Medications	40% Retail/40% Mail
Out-of-Pocket Maximum	All out-of-pocket expenses go towards In-Network Medical Out-of-Pocket Maximum.
Drug List	Essential Formulary
Other	- Specialty medications covered at participating retail pharmacies for first fill only. After first fill members use specialty pharmacies. - Specialty Medications and Self Administrable: Up to 30-day supply per fill. - Nonparticipating pharmacies not covered.

Pediatric Dental Services

- Various limits apply. - Covered for members up to age 19.	Member responsibility for both In-Network / Out-of-Network: Preventive: 0% Restorative: 20% Major: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum
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Pediatric Vision Services

- Covered for members up to age 19 - One routine eye exam per calendar year. - One pair (two lenses) and one standard frame per calendar year - Contacts covered in lieu of glasses	Member responsibility for both In-Network / Out-of-Network: Eye exam: 0% / Vision Hardware: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum
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Optional Benefits Available

PACKAGE OPTION:

Adult Dental, Adult Vision and IAP

Covered for members age 19 and older

Adult Dental

- No deductible and 0% for Preventive care
\$50 deductible per calendar year for Basic and Major Care
- 20% for Basic care
- 50% for Major care
- Adult dental waiting periods for enrollees with no prior coverage: 6 months for Basic Services and 12 months for Major Services.
- \$750 annual maximum (When services incurred are less than \$750, an additional benefit of \$250 may be rewarded the following year, not to exceed a total benefit of \$1,500)

Adult Vision

- No member responsibility for In-Network / Out-of-Network:
- One routine exam per calendar year Hardware limited to \$150 per calendar year
- Not subject to deductible

Individual Assistance Program (IAP)

- Eight sessions no member responsibility
- Reliant Behavioral Health Network

Additional Information

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.

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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 preventive service as specified under the Preventive Care and Immunizations benefit in the Medical Benefits Section.

- **Breast Reduction:** Except when following a Medically Necessary mastectomy, to the extent required by law, We do not cover breast reductions.
- **Complementary Care:** Except as provided in the Policy, We do not cover complementary care, including, but not limited to, the following: acupuncture, massage or massage therapy and the services of an acupuncturist, a massage therapist and a naturopath.
- **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.
- **Cosmetic/Reconstructive Services and Supplies** except 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 for certain preventive services under the Preventive Care and Immunizations benefit, We do not cover counseling in the absence of illness, for example: educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Individual Assistance Program ("IAP") services, except as specifically provided under the IAP Section, if applicable; wilderness programs; premarital or marital counseling; and family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits).
- **Custodial Care:** Non-skilled care and helping with activities of daily living.
- **Dental Services:** Except as provided in the Policy, We do not cover Dental Services provided to prevent, diagnose, treat diseases, or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.
- **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.
- **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 government 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).

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- **Growth Hormone Therapy:** Except as provided under the Prescription Medications benefit, We do not cover growth hormone therapy.
- **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. This exclusion does not apply to cochlear implants.
- **Infertility:** Treatment of infertility, except to the extent covered services are required to diagnose such condition. Non-covered treatment includes, but is not limited to, all assisted reproductive technologies (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), fertility drugs and medications, and other artificial means of conception.
- **Investigational Services:** Investigational treatments or procedures (Health Interventions) and 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.
- **Mental Health Treatment For Certain Conditions:** We will not cover Mental Health Conditions for diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) 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. By "V code," We mean codes for additional conditions that may be a focus of clinical attention as described in the most recent edition of the Diagnostic DSM-IV TR that describes Relational Problems, Problems Related To Abuse Or Neglect or other issues that may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problem
- **Motor Vehicle Coverage and Other Insurance Liability:** 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 of the Policy shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises 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 motor vehicle 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, We will provide benefits according to the Policy.
- **Non-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 specifically provided in the Policy.
- **Obesity or Weight Reduction/Control:** Except as provided in the Policy , We do not cover 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. This exclusion does not apply to reversals or revisions of surgery for obesity when required to correct a life-endangering condition. This exclusion also does not apply to treatment of obesity-related comorbid

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medical conditions; for example: diabetes, high blood pressure and heart disease.

- **Orthognathic Surgery:** 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. This exclusion does not apply to orthognathic surgery due to Illness, Injury or Congenital Anomaly.
- **Over the Counter Contraceptives:** Except as provided under the Prescription Medications benefit, 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 and light boxes.
- **Physical Exercise Programs and 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:** Private-duty nursing, including ongoing shift care in the home.
- **Reversal of Sterilizations:** services and supplies related to reversal 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:** Self-help, non-medical self-care, training programs, including: diet and weight monitoring services; childbirth-related classes including infant care and breast feeding classes; 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. 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 in the Policy (for example, nutritional counseling and diabetic education).
- **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 parents, spouse, children, siblings, half-siblings, parent-in-law, child-in-law, sibling-in-law, half-sibling-in-law, or any relative by blood or marriage who shares a residence with You.
- **Services and Supplies That Are Not Medically Necessary:** Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury, except for preventive care benefits specifically provided in the Policy.
- **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 policy.
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, or counseling services for sexual reassignment
- **Temporomandibular Joint (TMJ) Disorder Treatment:** Services and supplies provided for temporomandibular joint (TMJ) disorder treatment.
- **Third-Party Liability:** Services and supplies for treatment of illness or injury for which a third party is or

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may be responsible.

- **Tobacco Addiction Treatment:** Except as specifically provided in the Policy, We do not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.
- **Travel and Transportation Expenses:** Travel and transportation expenses other than covered ambulance services or as otherwise specifically provided in the Policy.
- **Vision Care:** Except as provided in the Policy we do not cover routine eye exam and vision hardware. We also do not cover visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals 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 You, Your spouse or Your domestic partner to file a claim for workers' compensation benefits before providing any benefits under the Policy. 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 You, Your spouse, or Your domestic partner is exempt from state or federal workers' compensation law.

General Pharmacy Exclusions

- **Biological Sera, Blood, or Blood Plasma**
- **Brand-Name Medications not on the Essential Formulary:** Except as provided through the Substitution Process in the Prescription Medications benefit, We do not cover Prescription Medications for Brand-Name Medications that are not on the Essential Formulary list.
- **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.
- **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 under the Durable Medical Equipment 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. 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.
- **Growth Hormones:** unless we preauthorize them.
- **Insulin Pumps and Pump Administration Supplies:** Coverage for insulin pumps and supplies is provided under the Diabetic Supplies and Equipment benefit.
- **Medications We Don't Consider Self-Administerable:** Coverage for these medications may otherwise be provided under the Medical Benefits Section.
- **Nonprescription Medications:** Medications that by law do not require a prescription order and which are not included in Our definition of Prescription Medications, unless included on Our Essential Formulary.
- **Prescription Medications Dispensed by a Nonparticipating Pharmacy:** Except as outlined in the Pharmacy Network Information section of the Prescription Medications benefit, We do not cover

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Prescription Medications dispensed by a Nonparticipating Pharmacy.

- **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 Used for Sexual Dysfunction or Enhancement**
- **Prescription Medications Without Examination:** Except as specifically allowed in the Policy, 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.
- **Professional Charges for Administration of Any Medication**
- **Travel Immunizations:** Immunizations for the purposes of travel, occupation or residency in a foreign country.

General Pediatric Dental Exclusions

- **Adjustments:** Adjustment of a denture or bridgework which is done within 6 months after insertion by the same Dentist who installed the denture or bridgework.
- **Aesthetic Dental Procedures:** Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth.
- **Bone Grafts:** Bone grafts done in connection with extractions, apicoectomies or non-covered/ineligible implant
- **Cone Beam Imaging/MRI Procedures**
- **Cosmetic/Reconstructive Services and Supplies:** Cosmetic and/or reconstructive services and supplies, except for Dentally Appropriate services and supplies to treat a Congenital Anomaly and to restore a physical bodily function lost as a result of Injury or Illness.
- **Decay Prevention:** Supplies and materials to prevent decay, such as toothpaste, fluoride gels, dental floss, and teeth whiteners.
- **Duplicate Services:** Services submitted by a Dentist which are for the same services performed on the same date for the same Member by another Dentist.
- **Experimental or Investigational Services**
- **Fabrication of Athletic Mouth Guard**
- **Facility Expenses:** Services and supplies related to facility expenses, including, but not limited to: those performed by a Dentist who is compensated by a facility for similar Covered Services performed for Member; and costs or any additional fees that the Dentist or Hospital charges for treatment at the

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- Hospital (inpatient or outpatient).
- **Failure to Comply:** Services and supplies resulting from Your failure to comply with professionally prescribed treatment.
- **Gold-Foil Restorations**
- **Oral Sedation**
- **Nitrous Oxide**
- **Oral Hygiene and Dietary Instructions**
- **Orthodontic Dental Services:** Except when Dentally Appropriate, We will not cover services and supplies provided in connection with orthodontics, including the following: correction of malocclusion; craniomandibular orthopedic treatment; other orthodontic treatment; preventive orthodontic procedures; procedures for tooth movement, regardless of purpose; and repair of damaged orthodontic appliances.
- **Plaque Control Programs**
- **Precision Attachments, Precious Metal Bases and Other Specialized Techniques**
- **Provisional, Temporary and Duplicate Devices or Appliances**
- **Replacements:** Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.
- **Separate Charges:** Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following: any supplies; local anesthesia; and sterilization (office infection control charges).
- **Services and Supplies to Alter Vertical Dimension and/or Restore or Maintain the Occlusion:** Services and supplies to alter vertical dimension and/or restore or maintain the occlusion, including the following: equilibration; periodontal splinting; full mouth rehabilitation; and restoration for misalignment of teeth.
- **Services and Supplies Which the Insured Would Have No Legal Obligation to Pay in the Absence of this Coverage**
- **Specialized Procedures and Techniques**
- **Temporomandibular Joint (TMJ) Disorder Treatment:** Services and supplies provided in connection with temporomandibular joint (TMJ) disorder.
- **Topical Medicament Center**

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.