Engage℠ Plan Highlights for Clark County

Engage's features:

◊ Provider choice: Members have direct access to their choice of providers. Category 1 are Preferred; Category 2 are Participating; and Category 3 are Non-contracted providers.

◊ Simplicity: One coinsurance level applies to all categories of providers. Members may be responsible for provider costs above the Category 3 allowed amount.

◊ Preventive care: Preventive exams including outpatient radiology and laboratory are included in the plan with no separate dollar maximum.

	Engage Plans
Lifetime Maximum Benefit	**$2,000,000**
Calendar Year Deductible Applies to all covered expenses except where noted	Individual deductible options per calendar year: **$0, $500, $1,000, $2,000, $3,000, $5,000** Family deductible is three times the individual amount
Calendar Year Coinsurance Maximum Applies to all covered expenses except where noted When the coinsurance maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year	Individual coinsurance maximum options per calendar year: **$2,000, $3,000, $4,000, $6,000** Family coinsurance maximum is three times the individual amount

Covered Services	**80% Plan** (Member may be responsible for any provider costs above the Category 3 allowed amount)	**70% Plan** (Member may be responsible for any provider costs above the Category 3 allowed amount)	**50% Plan** (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 coinsurance maximum is reached.		
Professional Services Office and inpatient services and supplies **Hospital Services/Ambulatory Surgical Center** Inpatient and outpatient services and supplies **Maternity** (Subscriber and Spouse)	**80%**	**70%**	**50%**

Effective 10/15/09

Coinsurance applies after deductible is met and until coinsurance maximum is reached.

Covered Services	80% Plan (Member may be responsible for any provider costs above the Category 3 allowed amount)	70% Plan (Member may be responsible for any provider costs above the Category 3 allowed amount)	50% Plan (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 coinsurance maximum is reached.		
Emergency Room Services $100 copay per ER visit (waived if directly admitted)			
Ambulance Services Air and ground ambulance to nearest facility	**80%**	**70%**	**50%**
Immunizations - Adult			
Immunizations - Childhood Covered to age 18 Not subject to deductible	**100%**	**100%**	**100%**
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)	**80%**	**70%**	**50%**
Prostheses $20,000 per calendar year maximum benefit (this limit does not apply to surgically implanted and external breast prostheses)			
Rehabilitation Services Inpatient: $25,000 per calendar year maximum benefit Outpatient: $1,500 per calendar year maximum benefit			

Covered Services	80% Plan (Member may be responsible for any provider costs above the Category 3 allowed amount)	70% Plan (Member may be responsible for any provider costs above the Category 3 allowed amount)	50% Plan (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 coinsurance maximum is reached.		
Neurodevelopmental Therapy For children age 6 and under Inpatient and outpatient combined: $1,500 per calendar year maximum benefit **Acupuncture** 12 visits per calendar year **Spinal Manipulations** 10 spinal manipulations per calendar year **Chemical Dependency** (Groups of 2-50): $14,500 combined inpatient / outpatient maximum benefit every 2 calendar years (Groups of 51+): No benefit maximums **Home Health** 130 visits per calendar year **Hospice** Respite care limited to 14 days inpatient / outpatient per lifetime **Mental Health** (Groups of 2-50): Inpatient: 8 days per calendar year Outpatient: 12 visits per calendar year (Groups of 51+): No benefit limits for inpatient/outpatient services **Skilled Nursing Facility** 60 inpatient days per calendar year **Temporomandibular Joint Disorders (TMJ) Treatment** $1,000 per calendar year maximum benefit **Transplants** Services and supplies to $250,000 lifetime maximum benefit $50,000 donor expense maximum benefit per transplant 6-month waiting period	**80%**	**70%**	**50%**

	Prescription Medication Options
Prescription Medication Coverage Tiered plan design with three copay / coinsurance maximum options and three deductible options Generics: not subject to deductible Retail: 30-day supply per copay Mail order: 90-day supply (one copay per 30-day supply) Copays and coinsurance apply to the out-of-pocket maximum	Prescription medication deductible options per calendar year: $0, $250, $500 (not applied to prescription medication out-of-pocket maximum) Copay options: $5 generic / $25 brand-name formulary / $50 brand-name nonformulary; $3,000 out-of-pocket maximum $7 generic / 25% brand-name formulary / 50% brand-name nonformulary; $4,000 out-of-pocket maximum $10 generic / 35% brand-name formulary / 50% brand-name nonformulary; $5,000 out-of-pocket maximum Member may be balance billed when a nonparticipating pharmacy is used If an equivalent generic medication is available and a brand-name medication is chosen, the member is responsible for paying the applicable brand-name copay / coinsurance plus the difference in price between the equivalent generic medication and the brand-name medication not to exceed total retail cost.

Covered Services	**Optional Benefits Available With All plans**		
	80% Plan	**70% Plan**	**50% Plan**
Spinal Manipulations Option with no benefit maximum	**80%**	**70%**	**50%**
Vision One routine eye exam per calendar year Hardware limited to $150 per calendar year maximum benefit Not subject to deductible	**100%**	**100%**	**100%**

Optional Program Available With All Plans	**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

Effective 10/15/09
Coinsurance applies after deductible is met and until coinsurance maximum is reached.

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 Regence plan with the same group for six consecutive months. There is a waiting period that must be met prior to benefits being available for pre-existing conditions: groups with 2-50 eligible employees have a nine-month pre-existing condition waiting period and groups with 51 or more eligible employees have a three-month pre-existing waiting period. 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 Exclusions Coverage is not provided for any of the following, including direct complications or consequences that arise from:	• **Cosmetic/Reconstructive Services and Supplies** except for reconstruction for functional injury and disease, to treat a congenital anomaly, 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

General Exclusions	
Coverage is not provided for any of the following, including direct complications or consequences that arise from:	• **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 • **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 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 or 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, and counseling services for sexual reassignment • **Sexual Dysfunction:** Regardless of cause, except for counseling provided by covered, licensed mental health practitioners • **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, including prescription medications • **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.