

SUMMARY OF BENEFITS INDIVIDUAL SELECTIONS® COMPREHENSIVE



**Regence
BlueShield**

An Independent Licensee of the Blue Cross
and Blue Shield Association

The benefits of this plan, for medically necessary services, will be provided at the percentage specified below, after the deductible and any applicable copays have been met. Unless otherwise specified, all benefits are subject to the annual deductible in addition to any copays and coinsurance. The Selections network offers you the most complete coverage. To be eligible you must choose a Personal Care Provider (PCP) from our list of Selections providers, except for self-referral benefits specified in your contract. Your PCP will manage your care; however when you need more specialized care, your PCP will refer you to a Selections specialist or extended network provider. The extended network offers you the freedom to choose from many of the providers who participate with the Company (Regence BlueShield). You may use these providers without a referral if you are willing to pay a greater share of the cost.

<u>Benefits</u>	<u>Selections-Network</u>	<u>Extended Network</u>
Annual Deductible Copays, prescription drugs, and preventive care do not count toward the deductible. Family deductible is met when three or more covered family members reach the equivalent of three individual deductible amounts in a calendar year	\$500 per individual/\$1,500 per family or \$1,000 per individual/\$3,000 per family	
Lifetime maximum	\$1,000,000 per individual	
Annual Out-of-Pocket Coinsurance Amount Family out-of-pocket coinsurance amount is met when three or more covered family members reach the equivalent of three individual out-of-pocket coinsurance amounts in a calendar year	\$2,000 per person \$6,000 per family	No out-of-pocket maximum
Professional Services \$15 professional copay in office, home, or hospital outpatient department. Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care providers	80%	50% (unless specified otherwise)
Hospital Facility (Inpatient and Outpatient)* Including diagnostic x-ray and laboratory \$75 copay per emergency room visit (waived if admitted)	80%	50%
Acupuncture \$15 professional copay 12 visits per calendar year maximum	80%	50%
Ambulance Services Ground services provided to \$2,000 per calendar year maximum	80%	80%
Blood Bank	80%	80%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	80%	50%
Home Medical Equipment \$5,000 per calendar year maximum	80%	50%
Home Phototherapy	80%	50%
Infusion Therapy Growth hormone only is limited to \$25,000 per calendar year	80%	50%
Mammography Routine mammograms not subject to deductible	80%	50%
Maternity	80%	50%
Outpatient Rehabilitation \$15 professional copay \$1,500 per calendar year maximum	80%	50%

Phenylketonuria (PKU) Formulas Not subject to waiting periods	80%	50%
Prescription Drugs \$2,000 per calendar year maximum; closed formulary; not subject to deductible	50%	50%
Preventive Care \$15 professional copay \$200 per calendar year maximum; not subject to deductible Routine exams, immunizations, well child care, and routine cancer screenings including preventive surgeries, such as colonoscopies	100%	not covered except for mammograms at 50%
Prostheses and Orthotics	80%	50%
Skilled Nursing Facility 30 days per calendar year maximum	80%	50%
Smoking Cessation \$500 lifetime maximum	80%	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations \$15 professional copay 10 manipulations per calendar year maximum	80%	50%
Transplants \$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum; 12-month waiting period	80%	see contract for criteria

*Services and supplies required to treat a medical emergency, inside the service area, will be provided at the Selections network payment level of benefits.

Copays: Each covered person will be required to pay a \$15 professional copay for certain services such as outpatient professional services performed in the office, home, hospital outpatient department, or other facility, and a \$75 copay for each visit to a hospital emergency room for illness, injury, or surgery (waived if directly admitted to the hospital as an inpatient). Copays do not apply toward the deductible or to the out-of-pocket coinsurance amount.

Annual Out-of-Pocket Coinsurance Amount: Benefits will be provided at the percentage specified until the annual out-of-pocket coinsurance (stoploss) maximum has been reached for the Selections network. When your eligible out-of-pocket coinsurance expenses for the Selections network have reached \$2,000 per person per calendar year, the payment level for most benefits within the Selections network only will increase to 100% of the allowed amount for the remainder of the calendar year. Any balances of charges not covered by this plan will be your responsibility to pay. The annual deductible, copays, outpatient rehabilitation, prescription drugs, and smoking cessation do not apply to the maximum stoploss amount. The maximum stoploss amount per family is three times the individual stoploss amount. There is no stoploss maximum on extended network benefits.

Emergency Care: Inside the service area, your plan will cover treatment by a network or non-network physician or hospital. You will receive the higher level of benefits only if you notify us within 24 hours or as soon as is reasonably possible, and you agree to follow our managed care guidelines. Otherwise, you will receive the lower level of benefits. Benefits will be based on the recognized provider's actual charge for the service.

Care Outside the Service Area: You have the same coverage and limitations for care outside our service area as you do within the extended network. However, any benefit payable at 50% will be paid at 80%, except benefits for prescription drugs which are paid at the level specified. Any additional charges will be your responsibility and you may have to submit your own claims. If you live in the service area and are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours to receive full plan benefits. You must also agree to comply with the Company's managed care guidelines, which may require you to move under the care of a Selections provider in the service area as soon as feasible. If you meet all requirements, inpatient benefits will be provided at the Selections network level. Preadmission approval is required for all inpatient admissions outside the service area if you seek care from providers that have not contracted with a Blue Cross and/or Blue Shield plan, except for emergency services or maternity admissions. When you need health care outside of the United States or its territories, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this or a prior plan with the Company for 12 consecutive months. No benefits will be provided for preexisting conditions, including maternity, until you have been covered under this plan for nine consecutive months, unless you were continuously covered for at least nine months under the immediately preceding creditable plan.

This is a brief summary of benefits; it is not a certificate of coverage. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, refer to the plan contract. Your feedback is important to us. If you have suggestions about the benefits covered under this plan, you may contact us at 1-888-344-8234 or visit our Web site at www.wa.regence.com and complete the Suggestion Box form located on the Contact page.