

**SUMMARY OF BENEFITS  
SELECTIONS**

Effective July 2010 – June 2011  
Renewing Groups

**80/50 \$30 Copay**

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 benefits brochure. 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. For chemical dependency and mental disorders benefits contact the Company at 1-800-780-7881 for referrals.

<b>Benefits</b>	<b>Selections Network</b>	<b>Extended Network</b>
<b>Annual Deductible</b> Copays do not count toward the deductible	None	\$500 per person \$1,500 per family
<b>Preventive Care</b> \$30 professional copay Routine exams, immunizations, well child care, and routine cancer screenings including preventive surgeries (no benefit maximum). One routine vision and hearing exam per calendar year maximum	80%	Not covered except for routine mammograms, routine colorectal and prostate cancer screening at 50%
<b>Professional Services</b> \$30 professional copay in office, home, or hospital outpatient department	80%	50%
<b>Hospital Facility (Inpatient and Outpatient)*</b> \$150 copay per emergency room visit (waived if admitted)	80%	50%
<b>Acupuncture</b> \$30 professional copay 12 visits per calendar year maximum	80%	50%
<b>Ambulance Services</b> Ground services provided to \$2,000 per calendar year maximum	80%	80%
<b>Blood Bank</b>	80%	80%
<b>Chemical Dependency</b>	80%	50%
<b>Colorectal Cancer Screening</b>	80%	50%
<b>Growth Hormone</b> \$25,000 per calendar year maximum	80%	50%
<b>Home Health and Hospice</b> Home health – 130 visits per calendar year maximum Hospice – 6 month maximum	80%	50%
<b>Home Medical Equipment, Prostheses and Orthotics</b>	80%	50%
<b>Hospitalization for Dental Services</b> \$1,000 per calendar year maximum No benefits provided for charges of a dentist	80%	50%
<b>Mammography Cancer Screening</b>	80%	50%
<b>Maternity</b> (provided for the subscriber or spouse)	same as any other condition	

<b>Mental Disorders</b>	80%	50%
<b>Neurodevelopmental Therapy</b> (for children age 6 and under) \$1,500 per calendar year maximum	80%	50%
<b>Occupational Injury</b> (provided for the subscriber only) \$250,000 lifetime maximum	80%	50%
<b>Prescription Drugs: Outpatient Retail</b> Prescription Drug Card Program Requires services of a participating retail pharmacy. 34-day supply for retail prescription services. Oral contraceptives are included in prescription drug card program. Prescription drug benefit is not subject to the medical plan deductible.	Covered at 100% after the member pays: \$10 copay for generic drugs \$30 copay for brand-name drugs on Regence formulary \$60 copay for non-formulary brand-name drugs (see additional prescription drug information below)	
<b>Prescription Drugs: Mail Order</b> Prescription Drug Card Program Requires services of a participating mail-order pharmacy. 90-day supply for mail order prescription services. Oral contraceptives are included in prescription drug card program. Prescription drug benefit is not subject to the medical plan deductible.	Covered at 100% after the member pays: \$20 copay for generic drugs \$60 copay for brand-name drugs on Regence formulary \$120 copay for non-formulary brand-name drugs (see additional prescription drug information below)	
<b>Phenylketonuria (PKU) Formulas</b>	80%	50%
<b>Prostate Cancer Screening</b>	80%	50%
<b>Rehabilitation</b> Inpatient - \$30,000 per condition Outpatient - \$20 professional copay; 1,500 per calendar year maximum	80%	50%
<b>Repair of Teeth**</b> \$1,000 per occurrence	80%	80%
<b>Skilled Nursing Facility</b> 90 days per calendar year maximum	80%	50%
<b>Smoking Cessation</b> \$500 lifetime maximum	80%	80%
<b>Special Equipment and Supplies</b>	80%	80%
<b>Spinal Manipulations</b> \$30 professional copay 10 spinal manipulations per calendar year maximum	80%	50%
<b>Temporomandibular Joint Disorders (TMJ)</b> \$1,000 per calendar year maximum; \$5,000 lifetime maximum	same as any other condition	
<b>Transplants</b> \$350,000 lifetime maximum \$50,000 per transplant donor organ procurement maximum \$2,500 per transplant travel and lodging maximum	80%	50%
<b>Minimum \$10,000 EMPLOYEE LIFE AND AD&amp;D BENEFIT</b> <b>\$15,000, \$25,000, and \$50,000 options available on a group basis</b>		

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

**Lifetime Maximum:** \$2,000,000

**Annual Out-of-Pocket Coinsurance:** The benefits of this plan will be provided at the percentage specified until the annual out-of-pocket coinsurance maximum has been reached for that network. Thereafter, this plan will provide most benefits at 100% of the allowed amount for the remainder of the calendar year for that network. Any balances of charges not covered by this plan will be your responsibility to pay. The annual deductible, copays, neurodevelopmental therapy, outpatient rehabilitation, repair of teeth, and smoking cessation do not apply to the maximum out-of-pocket coinsurance amount. The maximum annual out-of-pocket coinsurance amount is \$3,000 per individual/\$9,000 per family for the Selections Network and \$10,000 per individual/\$30,000 per family for the Extended Network.

**Copay:** There is a \$30 professional copay for each outpatient professional service in the office, home, hospital, or other facility. This amount will not apply for diagnostic laboratory and x-ray, outpatient surgery, radiation, chemotherapy, hospice, home health, home phototherapy, chemical dependency, and smoking cessation. Copays do not apply toward the deductible or to the out-of-pocket coinsurance amount.

**Emergency Care:** Inside the service area, your plan will cover treatment by a physician or hospital for a 24-hour period or longer to allow time for you to come under the care of one of our providers. 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.

**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%. 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, your inpatient care will be covered at the higher level of benefits provided you notify us within 24 hours of the admission and move under the care of a Selections provider when directed by the Company. 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.

**Prescription Drugs:** Prescription drugs (including oral contraceptives) and other covered items will be provided as described in your benefit booklet after you have paid the specified copay or coinsurance amount. Prescription drugs and other covered items must be furnished by a participating pharmacy or a participating mail order supplier. There are more than 1,100 participating pharmacies in the Washington State network from which to choose, as listed in our current provider directory. A list of these participating pharmacies, along with a list of participating out-of-state pharmacies is available on our Web site at [www.regencerox.com](http://www.regencerox.com). Benefits will be subject to any applicable waiting periods, limitations, and exclusions, except that prescription drug benefits will not be subject to the coordination of benefits provisions or to any medical deductible or medical coinsurance maximum described in your plan booklet.

**Formulary Provision:**

If you choose formulary or non-formulary drugs, the cost of formulary and non-formulary prescriptions will be determined according to whether you select a brand-name prescription medication or an exact generic equivalent medication available.

**Exact generic equivalent medication:**

An exact generic medication has the same chemical structure and the same effectiveness as the higher cost brand-name version of the drug.

**Here is an explanation of what this means to a member choosing between the generic and brand-name drug:**

If your prescription has an exact generic equivalent available and you select the brand-name medication, you will pay the brand-name drug copay and the difference in cost between the two medications at the time of purchase, but you will not pay more than the full retail cost of the brand-name medication. The difference in cost will not count toward your medical plan deductible or maximum coinsurance.

**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 six consecutive months. There is a preexisting condition waiting period that must be met prior to benefits being available. Refer to your benefits brochure for details regarding this waiting period. Maternity benefits and PKU benefits are not subject to the waiting periods of this 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 your benefits brochure and the contract on file with your group.**

**Please use the following phone number and address when you need to contact Regence BlueShield:**

<b>Mailing Address:</b>	<b>Street Address:</b>	<b>Subscriber and Provider Numbers:</b>
P.O. Box 21267	1800 Ninth Avenue	Toll-Free in Washington.....1-800-458-3523
Seattle, WA 98111-3267	Seattle, WA 98101-1322	TTY.....1-877-727-4357

**Regence BlueShield Web Site:** [www.wa.regence.com](http://www.wa.regence.com)

**Regence Pharmacy Web Site:** [www.regencerox.com](http://www.regencerox.com)

**Member's Personal Web Site:** [www.myregence.com](http://www.myregence.com)

**Your feedback is important to us. If you have suggestions about the benefits covered under this plan, you may contact us at 1-800-458-3523 or visit the Regence web site (above) and complete the Suggestion Box form located on the Contact page.**