BENEFIT SELECTION INSERT
FOR GROUPS OF 100 OR MORE ENROLLED EMPLOYEES

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association.

Group Name ______________________________

Group # ______________________________ Effective Date ______________

1. MEDICAL PLAN CHOICES for Preferred and Traditional Plans

Plan *(check those that apply)*	❒ **Preferred Plan 100/90/60**	❒ **Preferred Plan FourFront**	❒ **Preferred Plan 80/80/50**	❒ **Traditional 50% Plan**
Deductible *(check one)*	❒ $200 ❒ $500 ❒ $750 ❒ $1,000			$0
Deductible Waiver Option Deductible is waived for office visits when a copay applies and for outpatient diagnostic lab and x-ray services. *(check one)*	❒ Yes ❒ No	Not Applicable	Not Applicable	Not Applicable
Office Visit Copay *(check one)*	❒ $15 ❒ $20 ❒ $25	❒ $15 ❒ $25	Not Applicable	Not Applicable
Out-of-Pocket Coinsurance Maximum *(check one)*	❒ $2,500 ❒ $5,000			$5,000

Plan *(check one)*	❒ **HSA-Qualified Preferred Plan 80/80/60** **(only available for renewing groups that currently have one of these options)**	❒ **Regence HSA Healthplan**	
Deductible *(check one)*	❒ $1,500 Member / $3,000 Family ❒ $2,500 Member / $5,000 Family ❒ $3,500 Member / $7,000 Family	❒ $1,500 Member / $3,000 Family ❒ $2,500 Member / $5,000 Family ❒ $3,500 Member / $7,000 Family	❒ $3,000 Member / $5,000 Family (embedded deductible) ❒ $3,000 Member / $7,000 Family (embedded deductible)
Out-of-Pocket Coinsurance Maximum	$5,000 Member / $10,000 Family		

2. MEDICAL PLAN CHOICES for Selections® Plans

Plan *(check those that apply)*	❒ **Selections 100/70**	❒ **Selections 80/50**
Deductible	Selections Network - $0/Extended Network - $200	Selections Network - $0/Extended Network - $500
Professional Copay *(check one)*	❒ $15	❒ $20
Out-of-Pocket Coinsurance Maximum In Network *(check one)*	❒ $2,500 ❒ $5,000	
Extended Network	Standard $10,000	

3. OPTIONAL BENEFITS

Mental Disorders *(check one)*	
8 days inpatient/12 visits outpatient per calendar year are included in base **Preferred and Traditional** Plans - Option 12 **(please check box to the right if upgrade is purchased)**. Selections Network benefits – 12 days inpatient/15 visits outpatient per cal yr; Extended Network benefits – 6 days inpatient/12 visits outpatient per calendar year are included in base **Selections** Plans - Option 14	❒ Mental Disorders Option 13 (15 days inpatient/25 visits outpatient per calendar year) (Available with Preferred 100/90/60, Preferred 80/80/50, FourFront and Traditional plans)

"OPTIONAL BENEFITS" continued on reverse side

Spinal Manipulations 10 spinal manipulations are included in each base medical plan. (Please check appropriate box to the right if upgrade is purchased,)	❒ Spinal Manipulations #1 – Preferred/Traditional Plans - High Option (no specific spinal manipulation limit) ❒ Spinal Manipulations #4 - Selections Plans - High Option (no specific spinal manipulation limit)
Vision Care *(check one)* Selections Plans include a vision exam as a standard benefit.	❒ Exam and Schedule Hardware Benefit - Option 11 (Preferred/Traditional plans) ❒ Exam and 80% to $200 Hardware Benefit - Option 7 ($200 maximum benefit every two calendar years beginning with the initial date of service) (Preferred/Traditional plans) ❒ Schedule Hardware Benefit - Option 10 (Selections only) ❒ 80% to $200 Hardware Benefit - Option 9 ($200 maximum benefit every two calendar years beginning with the initial date of service) (Selections only) ❒ None
TMJ	Standard – included in rates quoted ($1,000 per calendar year / $5,000 per lifetime maximum benefit)
Traditional Dental Plans Refer to Group Master Application for participation requirements. *(check those that apply)*	❒ Indicate Traditional Dental Plan # ____________________ ❒ Orthodontia (50% to $1,000) ❒ None
Columbia Dental Plans Refer to Group Master Application for participation requirements. *(check those that apply)*	❒ Indicate CD Plan # ________________ ❒ Orthodontia ❒ None

4. OPTIONAL BENEFITS for all plans except HSA-Qualified Preferred Plan and Regence HSA Healthplan

Prescription Drugs *(check one)*	**Tiered – Open Formulary** ❒ $7 generic formulary/30% brand-name formulary/50% non-formulary copay ❒ $12 generic formulary/30% brand-name formulary/50% non-formulary copay ❒ $10 generic formulary/$20 brand-name formulary/$40 non-formulary copay	**Closed Formulary** ❒ $15 Copay ❒ $20 Copay ❒ 50% Copay to $2,000 maximum benefit per calendar year ❒ 20% Copay with $500 prescription drugs deductible per calendar year
Preventive Care Not applicable to Selections Plans. Selections Plans include preventive care benefits as a standard benefit. *(check one)*	❒ Preventive Care Option #14 (no specific benefit maximum per calendar year) ❒ Preventive Care Option #15 (deductible waived; subject to any applicable per-visit copay; benefit limited to $300 per person, per calendar year) ❒ None **Preferred Plan FourFront groups must choose one of the following options:** ❒ Preventive Care Option #17 (deductible waived; subject to any applicable per-visit copay; benefit limited to $300 per person, per calendar year) ❒ Preventive Care Option #18 (deductible waived; no specific benefit maximum per calendar year)	

5. NOTES – For groups currently enrolled on and renewing on a product or benefit option not included on this insert, please list any products/benefits not listed above