

BENEFIT OPTIONS SUMMARY

Preferred Plan FourFront



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

Regence BlueShield offers groups several ways to enhance our standard benefit packages. The following options are available to most groups unless indicated otherwise. Under Preferred Plan FourFront, all groups are required to choose a preventive care option, and a prescription drugs option. Contact your Sales Representative for more information.

<p>Annual Deductible Per Person</p> <p>The maximum annual deductible per family is three times the individual deductible amount.</p>	<p>\$200, \$500, \$750, or \$1,000</p>
<p>Office Visit Copay</p>	<p>\$15 or \$25</p>
<p>Annual Out-of-Pocket Coinsurance</p> <p>The maximum annual out-of-pocket coinsurance amount per family is three times the individual out-of-pocket coinsurance amount.</p>	<p>\$2,500 or \$5,000</p>
<p>Spinal Manipulations</p>	<p>An unlimited benefit is available. The member must use a Preferred Plan or participating provider.</p>
<p>Preventive Care – all groups must choose a preventive care option</p>	<p>Outpatient benefits are provided for routine well baby care, physical exams, immunizations, routine cancer screenings, including preventive surgeries and routine colorectal cancer screening services. Benefits are paid at 100% for Preferred Plan providers and at 50% for participating providers, and are subject to the office-visit copay amount. The annual deductible is waived.</p> <p>or</p> <p>Same as above, except all preventive care benefits will be limited to \$300 per person per calendar year. Routine colorectal cancer screening services are not subject to the preventive care annual maximum.</p>
<p>Dental Plans</p> <p>Not all dental plans are available throughout the service area; contact your Sales contact for complete details and to find out which plan works best for your group.</p>	<p>There are eight traditional dental plans to choose from. Annual maximums, payment levels, copays and deductibles vary among the plans.</p> <p>or</p> <p>There are four Columbia Dental plans available through several offices. These plans have no annual maximums or deductibles but have varying copays.</p>
<p>Orthodontia</p> <p>Traditional Dental</p> <p>Columbia Dental</p>	<p>Paid at 50% to \$1,000 lifetime maximum.</p> <p>Covered after \$2,800 copay.</p>
<p>Mental Disorders</p>	<p>Inpatient care limited to 8 days per calendar year. Outpatient care limited to 12 visits per calendar year.</p> <p>or</p> <p>Inpatient care limited to 15 days per calendar year. Outpatient care limited to 25 visits per calendar year.</p>

Vision Care

One routine eye exam per calendar year is covered when services are rendered by a Preferred Plan or participating physician, or a Preferred Plan or participating optometrist. Lenses and frames are paid to scheduled allowances beginning with the date of initial service for this benefit. Not subject to the deductible.

or

Same as above, except lenses and frames are paid at 80% to \$200 every two calendar years beginning with the date of initial service for this benefit.

Prescription Drugs –

Prescription drugs obtained through a participating retail pharmacy or participating mail-order program will be covered after the copay and prescription drugs deductible, if applicable, is satisfied. Prescription drug options include oral contraceptives.

Closed Formulary. Formulary outpatient prescription drugs are available with the following retail pharmacy copay amounts:

\$15 or \$20 per-prescription copay; prescriptions obtained through the mail-order program are also included at double the retail pharmacy copay.

or

\$500 prescription drugs deductible per calendar year. After the deductible is met, covered prescription drugs will be provided with a 20% per-prescription copay. Prescriptions obtained through the mail-order program are also included.

Tiered. Open formulary outpatient prescription drugs are available with the retail pharmacy copay amounts shown below. Since an open formulary is used, many non-formulary prescription drugs are covered but at a higher copay level for the member. The options are as follows:

\$7 generic/30% brand-name/50% non-formulary or \$12 generic/30% brand-name/50% non-formulary per-prescription copay; prescriptions obtained through the mail-order program are also included with a mail-order copay amount per prescription of \$14 generic/30% brand-name/50% non-formulary or \$24 generic/30% brand-name/50% non-formulary. These options are subject to a \$2,400 prescription drugs out-of-pocket per member per calendar year.

or

\$10 generic/\$20 brand-name/\$40 non-formulary per-prescription copay; prescriptions obtained through the mail-order program are also included at double the retail pharmacy copay.

This is a brief list of options, it is not a certificate of coverage. A complete statement of benefits, including waiting periods, limitations, and exclusions is available through your Sales contact. myRegence.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to www.myRegence.com and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.