SUMMARY OF BENEFITS
SELECTIONS® 100/70/15

Regence BlueShield is 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 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.

Benefits	Selections Network	Extended Network
Annual Deductible Copays do not count toward the deductible	none	$200 per person $600 per family
Preventive Care $15 professional copay Routine exams, immunizations, well child care, and routine cancer screenings including preventive surgeries. One routine vision and hearing exam per calendar year maximum	100%	not covered except for routine mammograms, routine colorectal and prostate cancer screening at 70%
Professional Services $15 professional copay in office, home, or hospital outpatient department	100% (unless otherwise specified)	70%
Hospital Facility (Inpatient and Outpatient)* $75 copay per emergency room visit (waived if admitted)	100%	70%
Acupuncture $15 professional copay 12 visits per calendar year maximum	100%	70%
Ambulance Services Ground services provided to $2,000 per calendar year maximum	80%	80%
Blood Bank	80%	80%
Chemical Dependency	100%	70%
Growth Hormone $25,000 per calendar year maximum	100%	70%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 month maximum	100%	70%
Home Medical Equipment, Prostheses and Orthotics	100%	70%
Hospitalization for Dental Services $1,000 per calendar year maximum No benefits provided for charges of a dentist	100%	70%
Mammography	100%	70%
Maternity (provided for the subscriber or spouse)	same as any other condition	
Mental Disorders Inpatient Outpatient - $15 professional copay	100%	70%
Neurodevelopmental Therapy (for children age 6 and under) $15 professional copay $1,500 per calendar year maximum	100%	70%
Occupational Injury (provided for the subscriber only) $250,000 lifetime maximum	100%	70%
Phenylketonuria (PKU) Formulas	100%	70%
Prostate Cancer Screening	100%	70%

(over)

Benefit		
Rehabilitation Inpatient - $30,000 per condition Outpatient - $15 professional copay; $1,500 per calendar year maximum	100%	70%
Repair of Teeth $1,000 per occurrence	80%	80%
Skilled Nursing Facility 90 days per calendar year maximum	100%	70%
Smoking Cessation $500 lifetime maximum	80%	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations $15 professional copay 10 spinal manipulations per calendar year	100%	70%
Temporomandibular Joint Disorders (TMJ) $1,000 per calendar year maximum; $5,000 lifetime maximum	100%	70%
Transplants $250,000 lifetime maximum; $50,000 per transplant donor organ procurement maximum; $2,500 per transplant travel and lodging maximum	100%	not covered

*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 per family is three times the individual out-of-pocket coinsurance amount. Refer to your benefits brochure for your specific annual out-of-pocket amount.

Copay: There is a $15 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 70% 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.

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. 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.