

# SUMMARY OF BENEFITS TRADITIONAL 50% PLAN



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

For medically necessary services rendered by a participating or recognized provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below. All benefits are subject to any copay and coinsurance.

When you have reached the annual out-of-pocket coinsurance maximum, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year, unless otherwise specified. Any balances of charges not covered by this plan will be your responsibility to pay.

Copays, neurodevelopmental therapy, outpatient rehabilitation, repair of teeth, and smoking cessation do not apply to the maximum out-of-pocket coinsurance amount.

Benefits	Participating Provider
<b>Professional Services</b> Including diagnostic x-ray and laboratory	50%
<b>Hospital Facility</b> Inpatient and outpatient including diagnostic x-ray and laboratory \$75 copay per emergency room visit (waived if admitted)	50%
<b>Acupuncture</b> 12 visits per calendar year maximum	50%
<b>Ambulance Services*</b>	50%
<b>Blood Bank*</b>	50%
<b>Chemical Dependency</b> \$14,500 every two calendar year maximum	50%
<b>Colorectal Cancer Screening</b>	50%
<b>Growth Hormone</b> \$25,000 per calendar year maximum	50%
<b>Home Health and Hospice</b> Home health - 130 visits per calendar year maximum Hospice - 6 month maximum	50%
<b>Home Medical Equipment, Protheses and Orthotics</b>	50%
<b>Home Phototherapy</b>	50%
<b>Hospitalization for Dental Services</b> \$1,000 per calendar year maximum No benefits provided for charges of a dentist	50%
<b>Mammography</b>	50%
<b>Maternity</b> (provided for the subscriber or spouse)	50%
<b>Mental Disorders</b> Inpatient - 8 days per calendar year Outpatient - 12 visits per calendar year	50% 50%
<b>Neurodevelopmental Therapy</b> (for children age 6 and under) \$1,500 per calendar year	50%

(over)

<b>Prostate Cancer Screening</b>	50%
<b>Occupational Injury</b> (provided for the subscriber only) \$250,000 lifetime maximum	50%
<b>Phenylketonuria (PKU) Formulas</b>	50%
<b>Rehabilitation</b> Inpatient - \$30,000 per condition Outpatient - \$1,500 per calendar year maximum	50%
<b>Repair of Teeth*</b> \$1,000 per occurrence	50%
<b>Skilled Nursing Facility</b> 90 days per calendar year maximum	50%
<b>Smoking Cessation</b> \$500 lifetime maximum	50%
<b>Special Equipment and Supplies</b>	50%
<b>Spinal Manipulations</b> 10 spinal manipulations per calendar year	50%
<b>Temporomandibular Joint Disorders (TMJ)</b> \$1,000 per calendar year maximum; \$5,000 lifetime maximum	50%
<b>Transplants</b> \$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum	50%

\* At this time, these services are provided only by recognized providers.

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

**Annual Out-of-Pocket Coinsurance Amount:** The total amount of coinsurance you are responsible to pay during a calendar year for covered services, after which the plan will provide benefits at 100 percent of the allowed amount for the remainder of that calendar year, unless otherwise specified. The maximum annual out-of-pocket coinsurance amount per family is three times the individual out-of-pocket coinsurance amount of \$5,000.

**Emergency Care:** In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a participating provider. Benefits will be based on the recognized provider's actual charge for the service.

**Care Outside the Service Area:** All care received outside the service area, whether or not a medical emergency, will be paid at the level specified for participating providers. Payment will be based on the allowed amount. Any balances of charges not covered by this plan will be your responsibility to pay. 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.

**Cost Containment Provisions:** All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is required for all inpatient admissions outside the service area if you seek care from providers who have not contracted with a Blue Cross and/or Blue Shield plan, except for emergency services or maternity admissions.

**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 (Regence BlueShield) 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](http://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.**