

SUMMARY OF BENEFITS
REGENCE BREAKTHRU 70
(A PREFERRED PLAN)



**Regence
BlueShield**

An Independent Licensee of the Blue Cross
and Blue Shield Association

For medically necessary services rendered by a Preferred Plan, participating, or recognized provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. Unless otherwise specified, all benefits are subject to the annual deductible in addition to any copays 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 for the services of Preferred Plan providers only, unless otherwise specified. Any balances of charges not covered by this plan will be your responsibility to pay.

The annual deductible, copays, prescription drugs, outpatient rehabilitation, vision hardware, and most participating provider services do not apply to the annual out-of-pocket coinsurance amount.

<u>Benefits</u>	<u>Preferred Plan Provider</u>	<u>Participating Provider</u>
Annual Deductible Copays, prescription drugs, preventive care, and the routine eye exam do not count toward the deductible. Family deductible is met when three or more covered family members reach the equivalent of three individual deductible amounts in a calendar year	\$1,000 per individual/\$3,000 per family or \$3,000 per individual/\$9,000 per family	
Lifetime maximum	\$2,000,000 per individual	
Annual Out-of-Pocket Coinsurance Amount Family out-of-pocket coinsurance amount is met when three or more covered family members reach the equivalent of three individual out-of-pocket coinsurance amounts in a calendar year	\$5,000 per person \$15,000 per family	No out-of-pocket maximum
Professional Services Office, home, and outpatient hospital visits; not subject to deductible	(unless specified otherwise)	
	100% after \$30 per-visit copay	100% after \$40 per-visit copay
Outpatient diagnostic x-ray and laboratory services; and other professional services; subject to deductible	70%	50%
Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers		
Hospital Facility (Inpatient and Outpatient) Including diagnostic x-ray and laboratory \$100 copay per emergency room visit (waived if admitted)	70%	50%
Acupuncture 12 visits per calendar year maximum	70%	50%
Ambulance Services** Ground services: \$2,000 per calendar year maximum	70%	70%
Blood Bank**	70%	70%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	70%	70%
Home Medical Equipment \$2,500 per calendar year maximum	70%	50%
Home Phototherapy	70%	70%
Infusion Therapy Growth hormone treatment is limited to \$25,000 per calendar year	70%	50%
Mammography Routine mammograms not subject to deductible	70%	50%
Maternity	70%	50%

(over)

Occupational Injury (provided for the subscriber only)	same as any condition	
Phenylketonuria (PKU) Formulas	70%	70%
Not subject to waiting periods		
Prescription Drugs	\$3,000 per calendar year maximum; not subject to deductible	
Generic Formulary	100% after \$10 Retail copay / 100% after \$20 Mail Order copay	
Brand-Name Formulary	70%	
Non-Formulary	50%	
Preventive Care	70%	50%
\$200 per calendar year maximum; not subject to deductible		
Routine exams, immunizations, well child care, and routine cancer screenings including preventive surgeries, such as colonoscopies		
Prostheses and Orthotics	70%	50%
Rehabilitation	70%	50%
Inpatient – \$4,000 per calendar year maximum		
Outpatient – \$2,000 per calendar year maximum		
Skilled Nursing Facility	*	70%
30 days per calendar year maximum		
Special Equipment and Supplies	70%	70%
Spinal Manipulations	70%	50%
10 manipulations per calendar year maximum		
Transplants	70%	50%
\$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum; 12-month waiting period		
Vision Care (not subject to deductible)		
One routine eye exam per calendar year	100% after \$30 copay	100% after \$40 copay
Vision hardware: \$200 per calendar year maximum	***	100%

*At this time, this service is provided only by participating providers.

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

***At this time, this service is provided only by participating or recognized optical providers.

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.

Emergency Care: Emergency benefits will be provided at the level specified for a Preferred Plan provider. 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 Preferred Plan provider. Benefits will be based on the recognized provider's actual charge for the service.

Copay: There is a per-visit copay for each office call/home visit billed as such by a provider in the office, home, or hospital outpatient department (waived for surgery, for radiation and chemotherapy, for spinal manipulations, or if you are directly admitted to the hospital as an inpatient). Copays do not apply toward the deductible or to the out-of-pocket coinsurance amount.

Care Outside the Service Area: All care received outside the service area will be paid the same as in the service area if you use a Preferred Plan or participating provider. Payment will be based on the allowed amount. To receive the highest benefit level, you must receive services from a Preferred Plan provider. If there is no Preferred Plan provider network in an area, benefits will be provided for care received from a participating provider at the level specified for Preferred Plan providers. Benefits will be provided for care received from a recognized provider at the level specified for Preferred Plan providers only, if there is no local Blue Cross and/or Blue Shield participating provider network in a particular area and for medical emergencies. Call 1-800-810-BLUE (2583) for names of Preferred Plan or participating providers with the local Blue Cross and/or Blue Shield plan. When you need health care outside of the United States or its territories, call the BlueCard Worldwide Service Center at 1-800-810-BLUE or call collect at 1-804-673-1177. If you are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours to receive full plan benefits. If you meet all requirements, inpatient benefits will be provided at the level specified for Preferred Plan providers for like services and supplies.

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 12 consecutive months. No benefits will be provided for preexisting conditions, including maternity, until you have been covered under this plan for nine consecutive months, unless you were continuously covered for at least nine months under the immediately preceding creditable 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 the plan contract. Your feedback is important to us. If you have suggestions about the benefits covered under

this plan, you may contact us at 1-888-344-8234 or visit our Web site at www.wa.regence.com and complete the Suggestion Box form located on the Contact page.