

**SUMMARY OF BENEFITS  
SELECTIONS® 80/50 \$25 COPAY**

**JULY 1, 2008**

For medically necessary services rendered by your Selections network Personal Care Provider or an extended network provider, the benefits of this plan will be provided at the percentage specified below after the deductible and any applicable copays have been met. For chemical dependency and mental disorder benefits contact the Company at 1-800-780-7881 for referrals.

<b>Benefits</b>	<b>Selections Network</b>	<b>Extended Network</b>
<b>Annual Deductible*</b> Copays do not count toward the deductible	None	\$500 per person \$1,500 per family
<b>Preventive Care</b> \$25 professional copay* Routine exams, immunizations, well child care, and cancer screenings One routine vision and hearing exam per calendar year	80%	Not covered except for mammograms and prostate cancer screenings at 50%
<b>Professional Services</b> \$25 professional copay in office, home or hospital outpatient department*	80%	50% (unless otherwise specified)
<b>Hospital Facility (Inpatient &amp; Outpatient)**</b> \$75 copay per emergency room visit (waived if admitted)*	80%	50%
<b>Acupuncture</b> \$25 professional copay* 12 visits per calendar year maximum	80%	50%
<b>Ambulance Services</b> Ground services provided to \$2,000 per calendar year	80%	80%
<b>Blood Bank</b>	80%	80%
<b>Chemical Dependency</b> \$14,000 every two calendar year maximum	80%	50%
<b>Growth Hormone</b> \$25,000 per calendar year maximum	80%	50%
<b>Home Health and Hospice</b> Home Health - 130 visits per calendar year maximum Hospice – 6 month maximum	80%	50%
<b>Home Medical Equipment, Protheses and Orthotics</b>	80%	50%
<b>Hospitalization for Dental Services</b> \$1,000 per calendar year maximum No benefits provided for charges of a dentist	80%	50%
<b>Maternity</b> (provided for the subscriber or spouse)	Same as any other condition	
<b>Mental Disorders</b> Inpatient Outpatient - \$25 professional copay*	80%	50%
	12 days per calendar year 15 visits per calendar year	6 days per calendar year 12 visits per calendar year
<b>Neurodevelopmental Therapy*</b> (for children age 6 and under) \$25 professional copay* \$1,500 per calendar year maximum	80%	50%
<b>Occupational Injury</b> (provided for the subscriber only) \$250,000 lifetime maximum	Same as any other condition	
<b>Rehabilitation</b> Inpatient - \$30,000 per condition Outpatient* - \$25 professional copay*; \$1,500 per calendar year maximum	80%	50%
<b>Repair of Teeth*</b> \$1,000 per occurrence	80%	80%
<b>Skilled Nursing Facility</b> 90 days per calendar year maximum	80%	50%

<b>Smoking Cessation*</b> \$500 lifetime maximum	80%	80%
<b>Special Equipment and Supplies</b>	80%	80%
<b>Spinal Manipulations</b> \$25 professional copay* 10 spinal manipulations per calendar year maximum	80%	50%
<b>Temporomandibular Joint Disorders (TMJ)</b> \$1,000 per calendar year maximum; \$5,000 lifetime maximum	80%	50%
<b>Transplants</b> \$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum	80%	Not covered
<b>Minimum \$10,000 EMPLOYEE LIFE AND AD&amp;D BENEFIT</b> <b>\$15,000 and \$25,000 Options available for Groups of 20 or more</b>		

\* Member copays and coinsurance do not apply to the out-of-pocket coinsurance amount.

\*\* Services and supplies required to treat a medical emergency, inside the service area, will be provided at the Selections network payment level of benefits.

**Selections Network Benefits:** 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 below. 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.

**Extended Network Benefits:** 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.

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

**Self-Referral Care:** You may refer yourself to a Selections physician, Selections optometrist, or an approved audiologist for routine vision and hearing exams. You may also self-refer to an approved smoking cessation provider. A female subscriber or dependent may refer herself to a Selections physician, Selections midwife, Selections advanced registered nurse practitioner specializing in women's health and midwifery, or Selections physician's assistant for covered women's health care services and receive the Selections network benefit level. You may also self refer to an approved chiropractor for covered chiropractic services and receive the Selections network benefit level. A subscriber or spouse may also refer herself to the specified above Selections or extended network providers for maternity benefits.

**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 benefits at 100% of the allowed amount for the remainder of the calendar year for that network. The annual deductible, per-visit copays, outpatient mental disorder care, neurodevelopmental therapy services, outpatient rehabilitation care, repair of teeth, and smoking cessation programs do not apply to the maximum out-of-pocket coinsurance amount. The maximum annual out-of-pocket coinsurance amount is \$2,500 per individual/\$7,500 per family for the Selections Network and \$10,000 per individual/\$30,000 per family for the Extended Network.

**Copay:** There is a \$25 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.

**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 50% 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 three-month preexisting condition waiting period that must be met prior to benefits being available. 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. Your feedback is important to us. If you have suggestions about the benefits covered under this plan, you may contact us at 1-800-458-3523 or visit our Web site at [www.wa.regence.com](http://www.wa.regence.com) and complete the Suggestion Box form located on the Contact page.