

# SUMMARY OF BENEFITS INDIVIDUAL REGENCE HSA HEALTHPLAN



Regence BlueShield is 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 coinsurance. When you, or you and your family, have reached the annual out-of-pocket 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 specified otherwise. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility to pay. Services provided by participating providers do not apply toward the annual out-of-pocket maximum.

<b>Benefits</b>	<b>Preferred Plan Provider</b>	<b>Participating Provider</b>
<b>Lifetime maximum</b>	\$2,000,000 per member	
<b>Annual Out-of-Pocket Amount</b> The total amount of coinsurance and deductible amount you, or you and your family, are responsible to pay during a calendar year for covered services, after which the plan will provide 100% of the allowed amount for the remainder of that calendar year, unless otherwise specified. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility to pay. The family out-of-pocket amount applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member at 100%, the entire family out-of-pocket maximum must be met.	\$5,000 member \$10,000 family	No out-of-pocket maximum
<b>Professional Services</b> Including diagnostic x-ray and laboratory. Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers.	80% (unless specified otherwise)	60%
<b>Hospital Facility (Inpatient and Outpatient)</b> Including diagnostic x-ray and laboratory	80%	60%
<b>Acupuncture</b> 12 visits per calendar year maximum	80%	60%
<b>Ambulance Services**</b> Ground services: \$2,000 per calendar year maximum	80%	80%
<b>Blood Bank**</b>	80%	80%
<b>Home Health and Hospice</b> Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	80%	80%
<b>Home Medical Equipment</b> \$2,500 per calendar year maximum	80%	60%
<b>Home Phototherapy</b>	80%	80%
<b>Infusion Therapy</b> Growth hormone treatment is limited to \$20,000 per calendar year	80%	60%
<b>Mammography</b> Routine mammograms not subject to deductible	80%	60%
<b>Mental Disorders</b> Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	80%	60%
<b>Occupational Injury (provided for the subscriber only)</b>	80%	60%
<b>Phenylketonuria (PKU) Formulas</b> Not subject to waiting periods	80%	80%

(over)

<b>Preventive Care (not subject to deductible)</b>	80%	60%
<b>Prostate Cancer Screening</b> Routine prostate cancer screenings not subject to deductible	80%	60%
<b>Prostheses and Orthotics</b>	80%	60%
<b>Rehabilitation</b> Inpatient - \$4,000 per calendar year maximum Outpatient - \$2,000 per calendar year maximum	80%	60%
<b>Skilled Nursing Facility</b> 30 days per calendar year maximum	*	80%
<b>Special Equipment and Supplies</b>	80%	80%
<b>Spinal Manipulations</b> 10 manipulations per calendar year maximum	80%	60%
<b>Transplants</b> \$250,000 lifetime maximum; 12-month waiting period	80%	60%

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

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

**Annual Deductible:** Refer to your contract for your specific deductible amount. Family deductible applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member, the entire family deductible must be met.

**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.

**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.

**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 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](http://www.wa.regence.com) and complete the Suggestion Box form located on the Contact page.**

# SUMMARY OF BENEFITS

## INDIVIDUAL REGENCE HSA

### HEALTHPLAN COMPREHENSIVE



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<b>Benefits</b>	<b>Preferred Plan Provider</b>	<b>Participating Provider</b>
<b>Lifetime maximum</b>	\$2,000,000 per member	
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<b>Mammography</b> Routine mammograms not subject to deductible	80%	60%
<b>Maternity</b>	80%	60%
<b>Mental Disorders</b> Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	80%	60%
<b>Newborn Care</b>	80%	60%
<b>Occupational Injury (provided for the subscriber only)</b>	80%	60%

(over)

<b>Phenylketonuria (PKU) Formulas</b> Not subject to waiting periods	80%	80%
<b>Prescription Drugs</b> \$2,000 per calendar year maximum; closed formulary	*	50%
<b>Preventive Care (not subject to deductible)</b>	80%	60%
<b>Prostate Cancer Screening</b> Routine prostate cancer screenings not subject to deductible	80%	60%
<b>Prostheses and Orthotics</b>	80%	60%
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