



WBACC Selections 80/50/15 Plan

In The Service Area

Selections Network Benefits

The Selections Network Benefits offer the most complete coverage. To be eligible for this level of benefits, you must choose a Personal Care Provider (PCP) from the list of Selections providers who will manage your care. When you need more specialized care, your PCP will refer you to a Selections specialist or extended network provider. You pay copay at the time you receive most outpatient services and a percentage of eligible expenses (coinsurance) up to the out-of-pocket maximum per calendar year. Then, except for copays, your plan pays most benefits in full for the rest of the year. Copays do not count toward the out-of-pocket maximum.

In the Service Area

Extended Network Benefits

The Extended Network Benefits offer you the freedom to choose from any of the providers who participate with Regence BlueShield. You may use these providers without a referral if you are willing to pay a greater share of the cost. As in the Selections Network, you pay a copay at the time you receive most outpatient services. Plus, you pay an annual deductible and a larger coinsurance on eligible expenses up to the out-of-pocket maximum per calendar year. Then, except for copays, your plan pays most benefits in full for the rest of the year. Copays do not count towards the deductible, and the deductible and copays do not count toward the out-of-pocket maximum.

To determine if a provider is in the “**Selections Network**”, refer to the Regence BlueShield Selections Provider directory, The Regence Website www.wa.regence.com or call one of the WBACC Member Service Specialists at Regence BlueShield.

	Selections Network Benefits	Extended Network Benefits
Lifetime Maximum	\$2,000,000	\$2,000,000
Annual Deductible	\$100 per person/\$300 per family	\$200 per person/\$600 per family
Annual Coinsurance Out-Of-Pocket Maximum	\$2,500 per person/\$7,500 per family	\$10,000 per person/\$30,000 per family

Benefits: All benefits subject to deductible unless otherwise stated		
Preventive Care \$15 copay. Routine Exams, immunizations, well child care, and routine cancer screening tests.	80% No copay on lab or x-ray services	No coverage except 50% for mammograms and prostate cancer screenings No copay on lab or x-ray services
Professional Visits \$15 copay for injury and illness conditions, including DX&L mammography & prostate cancer screenings	80%	50%
Hospital Inpatient & outpatient including mammography & prostate cancer screenings	80%	50%
Skilled Nursing Facility Skilled nursing facility limited to 90 days per calendar year	80%	50%
Emergency Room \$150 per visit (copay waived if admitted)	80%	50%
Ambulance Ground services provided to \$2,000 per calendar year.	80%	80%,
Chemical Dependency Treatment Facility \$14,500 maximum every 2 calendar years.	80%	50%
Home Health 130 visits per calendar year	80%	50%
Hospice Services Six months	80%	50%
Maternity	Same as any other condition. Coverage is provided for subscriber or spouse. You may refer yourself to a Selections obstetrical specialist from the list of Selections providers.	Same as any other condition, Coverage is provided for subscriber or spouse. You may refer yourself to a Selections obstetrical specialist from the list of Selections providers.
Mental Disorder Care		
Inpatient	80% to 12 days per calendar year	50% to 6 days per calendar year
Outpatient- \$15 Copay	80% to 15 visits per calendar year (not included in the stoploss amount).	50% to 12 visits per calendar year (not included in the stoploss amount).

Neurodevelopmental Therapy (Children under age 7) \$1,000 per calendar year for all services combined.		
Inpatient	80%	50%
Outpatient- \$15 copay	80%	50%
Prescription Drugs	Approved Pharmacies: \$10/35/70, Mail Order, 90 days \$20/70/140 \$150 per member deductible on brand name and non-formulary drugs	Same
Rehabilitative Care		
Inpatient- \$30,000 per condition	80%	50%
Outpatient- \$15 copay to \$1,000 per calendar year - not included in the stoploss amount	80%	50%
Spinal Manipulations \$15 Copay to 10 manipulations per calendar year	80%	50%
Acupuncture \$15 copay to 12 visits per calendar year	80%	50%
Smoking Cessation Programs \$500 lifetime maximum/not included in stoploss amount	80%	80%
Transplants - 12 month waiting period Coverage is provided only for specific transplants that have been preapproved and performed at the designated facility as selected by Regence BlueShield. Coverage is limited to \$250,000 maximum for all transplants and related costs.	80%	Not covered

OUTSIDE THE SERVICE AREA

Same coverage and provisions as in the Extended Network, except benefits paid at 50% will be paid 80%. Any additional charges will be your responsibility, and you may have to submit your own claims.

This is a brief summary of benefits. For full coverage provisions, including a description of waiting periods, limitations and exclusions, refer to your benefit booklet. This plan is underwritten by Regence BlueShield of Seattle, WA. *An Independent Licensee of the Blue Shield Association.