



## WBACC Selections 100/70/15 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 a 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](http://www.wa.regence.com) or call one of the WBACC Member Service Specialists at Regence BlueShield.

	<b>Selections Network Benefits</b>	<b>Extended Network Benefits</b>
<b>Lifetime Maximum</b>	\$2,000,000	\$2,000,000
<b>Annual Deductible</b>	\$0	\$200 per person/\$600 per family
<b>Annual Coinsurance Out-Of-Pocket Maximum</b>	\$2,500 per person/\$7,500 per family	\$10,000 per person/\$30,000 per family

<b>Benefits:</b> All benefits subject to deductible unless otherwise stated		
<b>Preventive Care</b> \$15 copay. Routine Exams, immunizations, well child care, and routine cancer screening tests.	100% No copay on lab or x-ray services	No coverage except 70% for mammograms and prostate cancer screenings No copay on lab or x-ray services
<b>Professional Visits</b> \$15 copay for injury and illness conditions, including DX&L mammography & prostate cancer screenings	100%	70%
<b>Hospital</b> Inpatient & outpatient including mammography & prostate cancer screenings	100%	70%
<b>Skilled Nursing Facility</b> Skilled nursing facility limited to 90 days per calendar year	100%	70%
<b>Emergency Room</b> \$75 per visit -copay waived if admitted	100%	70%
<b>Ambulance</b> Ground services provided to \$2,000 per calendar year	80%	80%
<b>Chemical Dependency Treatment Facility</b> \$14,000 maximum every 2 years	100%	70%
<b>Home Health</b> 130 visits per calendar year	100%	70%
<b>Hospice Services</b> Six months	100%	70%
<b>Maternity</b>	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.
<b>Mental Disorder Care</b>		
Inpatient	100% to 12 days per calendar year	70% to 6 days per calendar year
Outpatient- \$15 copay	100% to 15 visits per calendar year (not included in the stoploss amount).	70% to 12 visits per calendar year (not included in the stoploss amount).

<b>Neurodevelopmental Therapy</b> (Children under age 7) \$1,000 per calendar year for all services combined.		
Inpatient	100%	70%
Outpatient- \$15 copay	100%	70%
<b>Prescription Drugs</b>	Approved Pharmacies: \$10/35/70, Mail Order , 90 days \$20/70/140	Same
<b>Rehabilitative Care</b>		
Inpatient- \$30,000 per condition	100%	70%
Outpatient- \$15 copay to \$1,000 per calendar year-not included in the stoploss amount	100%	70%
<b>Spinal Manipulations</b> \$15 copay - 10 Spinal manipulations per calendar year	100%	70%
<b>Acupuncture</b> \$15 copay to 12 visits per calendar year	100%	70%
<b>Smoking Cessation Programs</b> \$500 lifetime maximum/not included in stoploss amount	80%	80%
<b>Transplants</b> 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.	100%	Not covered

**OUTSIDE THE SERVICE AREA**

Same coverage and provisions as in the Extended Network, except benefits paid at 70% 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.