



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 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/\$300 person/family	\$200/\$600 person/family
Annual Coinsurance Out-Of-Pocket Maximum	\$2,500 per person/\$7,500 per family	\$10,000 per person/\$30,000 per family

Benefits		
Preventive Care \$15 copay. Routine Exams, immunizations, well child care, and routine cancer screening tests.	100% after (no copay for lab or x-ray services).	No coverage except 70% for mammograms (no copay on lab or x-ray services)
Physician and Nurse Services \$15 copay. For injury and illness conditions	100%	70%
Diagnostic X-ray and Lab Services	100%	70%
Inpatient Hospital and Skilled Nursing Facility Skilled nursing facility limited to 90 days per calendar year	100%	70%
Emergency Room \$75 per visit -copay waived if admitted	100%	70%
Ambulance Ground services provided to \$2,000 per calendar year	80%	80%
Chemical Dependency Treatment Facility \$13,500 maximum every 2 years	100%	70%
Home Health 130 visits per calendar year	100%	70%
Hospice Services Six months	100%	70%
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	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).

Neurodevelopmental Therapy (Children under age 7) \$1,000 per calendar year for all services combined.		
Inpatient	100%	70%
Outpatient- \$15 copay	100%	70%
Prescription Drugs	Approved Pharmacies: <ul style="list-style-type: none"> • \$10 copay generic • \$20 copay covered name brand • \$40 copay non-formulary • Mail Order Service: • \$20 copay generic • \$40 copay covered name brand • \$80 copay non-formulary Up to a 90-day supply per purchase	Same
Rehabilitative Care		
Inpatient- \$30,000 per condition	100%	70%
Outpatient- \$15 copay to \$1,000 per calendar year-not included in the stoploss amount	100%	70%
Chiropractic Care \$15 copay - 10 Spinal manipulations per calendar year	100%	70%
Acupuncture \$15 copay to 12 visits per calendar year	100%	70%
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.	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.

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