H S A
1500

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.

Benefits	Preferred Plan Provider	Participating Provider
Calendar Year Deductible	$1,500 Per Person	
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.	$3,000 Per Family	
Stoploss Amount (Out-of-Pocket Maximum)	$5,000 Per Person	
Per Calendar Year (Includes Calendar Year Deductible)	$10,000 Per Family	
Professional Services Including diagnostic x-ray and laboratory	80% (unless otherwise specified)	60%
Hospital Facility Inpatient and outpatient including diagnostic x-ray and laboratory	80%	60%
Acupuncture 12 visits per calendar year maximum	80%	60%
Ambulance Services**	80%	80%
Blood Bank**	80%	80%
Chemical Dependency	80%	60%
Growth Hormone $20,000 per calendar year maximum	80%	60%
Home Health and Hospice Home health - 130 visits per calendar year maximum Hospice - 6 month maximum	80%	80%
Home Medical Equipment, Prostheses and Orthotics	80%	60%
Home Phototherapy	80%	80%
Hospitalization for Dental Services $1,000 per calendar year maximum No benefits provided for charges of a dentist	80%	60%
Maternity (provided for the subscriber or spouse)	same as any other condition	
Mammography	80%	60%
Mental Disorders	80%	60%
Neurodevelopmental Therapy (for children age 6 and under) $1,500 per calendar year maximum	80%	60%
Occupational Injury (provided for the subscriber only) $250,000 lifetime maximum	80%	60%
Phenylketonuria (PKU) Formulas	80%	80%

(over)

Benefit		
Prescription Drugs 90 day supply limit / Mail Order- 90 day supply limit	*	80%
Preventive Care (not subject to deductible)	80%	60%
Prostate Cancer Screening	80%	60%
Rehabilitation Inpatient - $30,000 per condition Outpatient - $1,500 per calendar year maximum	80%	60%
Repair of Teeth** $1,000 per occurrence	80%	80%
Skilled Nursing Facility 90 days per calendar year maximum	*	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations 10 spinal manipulations per calendar year	80%	60%
Temporomandibular Joint Disorders (TMJ) $1,000 per calendar year maximum; $5,000 lifetime maximum	80%	60%
Transplants $350,000 lifetime maximum	80%	60%

* At this time, this service is provided only by participating providers.
** At this time, these services are provided only by recognized providers.

Lifetime Maximum: $2,000,000

Annual Deductible: $1,500 per individual / $3,000 per family. Family deductible applies when the subscriber and one or more dependents are enrolled.

Annual Out-of-Pocket Amount: $5,000 Member/$10,000 Family. 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 benefits at 100 percent 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 you 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.

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 or participating 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 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 (2583) or call collect at 1-804-673-1177.

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 or maternity admissions.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this medical plan for six consecutive months. There is a preexisting condition waiting period that must be met prior to benefits being available. Refer to your benefits brochure for details regarding this waiting period. 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. myRegence.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to www.myRegence.com and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.

SUMMARY OF BENEFITS

PRESCRIPTION DRUGS

80%

Getting Your Prescription Filled: Prescription drugs and other covered items must be furnished by an approved pharmacy or a participating mail order supplier. There are more than 1,200 approved pharmacies in our Washington State network from which to choose, as listed in our current provider directory. A list of these participating pharmacies, along with a list of participating out-of-state pharmacies is available on our website at www.regencerx.com.

- Present your identification card at an approved pharmacy.
- Prescription drugs furnished by an approved pharmacy will be limited to a 100-day supply, except as otherwise specified.
- **You must pay for your entire prescription at the time you purchase it. Regence will then mail you a check less deductible and/or coinsurance responsibility.**

Major Medical Prescription Drug Card: Participants covered by Regence or one of its subsidiaries will have the benefit of automatic claims submission for prescription drugs when using an approved pharmacy. Each employee/subscriber will receive a "Prescription Drug Card." **You must still pay for your prescription at the time you purchase it**, however, presenting the "Prescription Drug Card" at an approved pharmacy will provide the advantage of automatic claims submission and of the discounted prices available to approved pharmacies. **Prescription drug charges are still subject to the deductible and co-insurance provisions of your contract.**

Using Our Mail Order Service:

- Pay the full amount of the prescription.
- Send an order form and the prescription along with the full amount of the prescription to the address listed on the mail order service form.
- The Company will reimburse you at 80% of the allowed amount.
- Prescription drugs furnished by mail order will be limited to a 90-day supply per purchase, except that certain drugs, including but not limited to antidepressants, narcotics, and other select medications may be limited to a lesser supply as indicated on your prescription or as required by the Company.
- Drugs requiring continuous refrigeration may not be available through mail order service.

Prescription drugs (including oral contraceptives) and other covered items will be provided as described below after you have paid the specified copay amount. **Benefits will be subject to any applicable waiting periods, limitations and exclusions.**

FORMULARY	A formulary is a list of selected generic and brand-name preferred drugs, which is established, reviewed, and updated routinely by the Company. You will be required to pay more if the drug does not appear in the formulary. All drugs are reviewed and selected for inclusion in the Company's formulary by an outside committee of providers, including physicians and pharmacists. Drugs are selected based on published scientific evidence and support proper use and cost-effective medication decisions. If clinical data show several drugs are equally effective, the committee usually chooses the most cost effective ones. For your convenience, the list is available on our website at www.regencerx.com.
DEDUCTIBLE	The $1500 annual deductible must be satisfied before any pharmacy benefits will be paid.
COINSURANCE	You will be responsible for paying the coinsurance amount of **20%** for each covered prescription or refill. **Approved Pharmacies ……………………………………………80% of the allowed amount**

Covered Items: Prescription drugs will be covered when medically necessary for the treatment of an illness, accidental injury, or disability covered under this plan, subject to all provisions described below. Other items covered under this benefit and requiring a prescription include:

- Legend vitamins for prenatal care.
- Smoking cessation prescription drugs and medications, limited to a 90-day lifetime maximum supply.
- Diabetic supplies, including insulin and insulin syringes.
- For oral contraceptive drugs, a maximum of three prepackaged monthly cycles may be purchased at one time.

Limitations: Benefits for prescription drugs and other covered items will be limited as follows:

- Prescription drugs must be prescribed by a provider covered under the plan who is acting within the scope of his or her license.
- Certain prescription drugs require preauthorization from the Company before they are covered. Participating pharmacies have been provided with a list of those drugs along with preauthorization requirements.
- Prescription drugs related to transplants are covered under this Prescription Drugs Benefit; however, claims for such drugs will be applied to and are subject to the Transplants Benefit maximum of the plan.
- Certain drugs may be limited to a lesser supply as indicated on your prescription or as determined by the Company. Participating pharmacies have been provided with a list of those drugs.
- Any drug purchased outside the United States must have an equivalent to a prescription drug approved by the FDA to be a covered benefit under this plan, and must be either:
    - Associated with a medical emergency while you are traveling. When submitting a claim for reimbursement, you will be responsible for notifying the Company that the prescription was required for a medical emergency; or
    - When you are residing outside the United States. When submitting a claim for reimbursement, you will be responsible for notifying the Company that your residence is outside the United States. The medication needs to be purchased in the country in which you are residing, except for a medical emergency.
- The Company may require you to obtain all prescriptions from a single approved pharmacy.

Exclusions: The following items are not covered under this Prescription Drugs Benefit due to contract exclusions or, as noted, covered under another benefit of the plan:

- Any items limited or excluded by the medical plan, except where specifically provided.
- Appetite suppressants and drugs for weight loss.
- Drugs or medications used for cosmetic purposes.
- Drugs dispensed by a non-approved pharmacy, except when specifically provided for cases of emergency or outside the service area.
- Inside the United States, any prescription drug that has not been approved by the FDA, including compounded products with active ingredient(s) that have not been approved by the FDA.
- Any drugs or items obtained from a participating pharmacy when you fail to present the identification card.
- Over-the-counter medications (OTC) and any prescription medication with the same active ingredients and in the same strength as an over-the-counter product.
- Replacement prescriptions resulting from loss, theft, or breakage.
- Oral progesterone compounded products.
- Any drugs or items in excess of the specific limits described above.

This is a brief description of a prescription drug option.