

**RBS Progressive \$200**  
**SUMMARY OF BENEFITS**  
**PPO 90/80/60/20**



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. When you have reached the annual out-of-pocket coinsurance maximum, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year, unless otherwise specified. Any balances of charges not covered by this plan will be your responsibility to pay. The annual copays, neurodevelopmental therapy, outpatient rehabilitation, repair of teeth, and smoking cessation do not apply to the maximum out-of-pocket coinsurance amount.

<b>Benefits</b>	<b>Preferred Plan Provider</b>	<b>Participating/Recognized Provider</b>
<b>Professional Services</b> \$20 per-office visit copay for office, home, and outpatient hospital visits; Office, home, and hospital outpatient department visits are not subject to deductible when subject to copay; outpatient diagnostic x-ray and laboratory services are not subject to deductible	90% (unless otherwise specified)	60%
<b>Hospital Facility***</b> Inpatient and outpatient including diagnostic x-ray and laboratory \$150 copay per emergency room visit (waived if admitted)	80%	60%
<b>Acupuncture</b> 12 visits per calendar year maximum; subject to the deductible	90%	60%
<b>Ambulance Services**</b>	80%	80%
<b>Blood Bank**</b>	80%	80%
<b>Chemical Dependency</b> \$14,500 every two calendar year maximum	90%	60%
<b>Colorectal Cancer Screening</b>	90% professional 80% facility	60%
<b>Growth Hormone</b> \$25,000 per calendar year maximum	90%	60%
<b>Home Health and Hospice</b> Home health - 130 visits per calendar year maximum Hospice - 6 month benefit maximum; 14 day inpatient maximum	90%	90%
<b>Home Medical Equipment, Prostheses and Orthotics</b>	90%	60%
<b>Home Phototherapy</b>	90%	90%
<b>Hospitalization for Dental Services</b> \$1,000 per calendar year maximum No benefits provided for charges from a dentist	90% professional 80% facility	60%
<b>Mammography</b>	90% professional 80% facility	60%
<b>Maternity</b> (provided for the subscriber or spouse)	same as any other condition	
<b>Mental Disorders</b> Inpatient - 8 days per calendar year Outpatient - 12 visits per calendar year	90% professional 80% facility	60%
<b>Neurodevelopmental Therapy</b> (for children age 6 and under) \$1,500 per calendar year maximum	90%	60%
<b>Occupational Injury</b> (provided for the subscriber only) \$250,000 lifetime maximum	same as any other condition	
<b>Phenylketonuria (PKU) Formulas</b>	90%	90%

<b>Preventive Care</b> \$500 annual maximum, not subject to deductible	90% professional 80% facility	60%
<b>Prostate Cancer Screening</b>	90% professional 80% facility	60%
<b>Rehabilitation</b> Inpatient - \$15,000 per condition	90% professional 80% facility	60%
Outpatient - \$1,000 per calendar year maximum	90%	60%
<b>Repair of Teeth**</b> \$1,000 per occurrence	80%	80%
<b>Skilled Nursing Facility</b> 30 days per calendar year maximum	*	90%
<b>Smoking Cessation</b> \$500 lifetime maximum	75%	75%
<b>Special Equipment and Supplies</b>	80%	80%
<b>Spinal Manipulations</b> 12 spinal manipulations per calendar year, not subject to deductible	90%	60%
<b>Temporomandibular Joint Disorders (TMJ)</b> \$1,000 per calendar year maximum; \$5,000 lifetime maximum	same as any other condition	
<b>Transplants</b> \$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum	90% professional 80% facility	60%

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

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

\*\*\* Services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits.

**Lifetime Maximum:** \$2,000,000

**Annual Deductible:** \$200 per individual / \$400 per family. The deductible is waived for professional services billed as office visits in the office, home, or hospital outpatient department and for outpatient diagnostic x-ray and laboratory. Services provided by professionals that are not subject to the per-visit copay are subject to the annual deductible.

**Annual Out-of-Pocket Coinsurance Amount:** The total amount of coinsurance you 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. The annual deductible, copays, neurodevelopmental therapy, outpatient rehabilitation, repair of teeth, and smoking cessation do not apply to the maximum out-of-pocket coinsurance amount. \$1,500 per individual/ \$3,000 per family.

**Copay:** There is a \$20 per-visit copay for each office call/home visit billed as such by a provider in the office, home, or hospital outpatient department (waived for surgery, for radiation and chemotherapy, for spinal manipulations, or if you are directly admitted to the hospital as an inpatient). Copays do not apply toward the deductible or to the out-of-pocket coinsurance amount.

**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, participating, or non-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 or non-participating provider at the level specified for Preferred Plan providers. 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 or a prior plan with the Company (Regence BlueShield) 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](http://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.**