

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.

| <b>Benefits</b>  | <b>Preferred Plan Provider</b>      | <b>Participating Provider</b> |
|--|-------------------------------------|-------------------------------|
| <b>Professional Services</b><br>Including diagnostic x-ray and laboratory  | 80%<br>(Unless Otherwise Specified) | 60%                           |
| <b>Hospital Facility</b><br>Inpatient and outpatient including diagnostic x-ray and laboratory                                   | 80%                                 | 60%                           |
| <b>Acupuncture</b><br>12 visits per calendar year maximum  | 80%                                 | 60%                           |
| <b>Ambulance Services**</b>  | 80%                                 | 80%                           |
| <b>Blood Bank**</b>  | 80%                                 | 80%                           |
| <b>Chemical Dependency</b>   | 80%                                 | 60%                           |
| <b>Growth Hormone</b><br>\$20,000 per calendar year maximum  | 80%                                 | 60%                           |
| <b>Home Health and Hospice</b><br>Home health - 130 visits per calendar year maximum<br>Hospice - 6 month maximum                | 80%                                 | 80%                           |
| <b>Home Medical Equipment, Protheses and Orthotics</b>   | 80%                                 | 60%                           |
| <b>Home Phototherapy</b>   | 80%                                 | 80%                           |
| <b>Hospitalization for Dental Services</b><br>\$1,000 per calendar year maximum<br>No benefits provided for charges of a dentist | 80%                                 | 60%                           |
| <b>Maternity</b> (Provided for the subscriber or spouse)   | Same as Any Other Condition         |                               |
| <b>Mammography</b>   | 80%                                 | 60%                           |
| <b>Mental Disorders</b>  | 80%                                 | 60%                           |
| <b>Neurodevelopmental Therapy</b> (For children age 6 and under)<br>\$1,500 per calendar year maximum                            | 80%                                 | 60%                           |
| <b>Occupational Injury</b> (Provided for the subscriber only)<br>No lifetime maximum   | 80%                                 | 60%                           |
| <b>Phenylketonuria (PKU) Formulas</b>  | 80%                                 | 80%                           |
| <b>Prescription Drugs</b>  | *                                   | 80%                           |
| <b>Preventive Care</b> (Not subject to deductible)<br>No annual maximum  | 80%                                 | 60%                           |

|   |     |     |
|---|-----|-----|
| <b>Prostate Cancer Screening</b>  | 80% | 60% |
| <b>Rehabilitation</b><br>Inpatient - \$30,000 per condition<br>Outpatient - \$1,500 per calendar year maximum | 80% | 60% |
| <b>Repair of Teeth**</b><br>\$1,000 per occurrence  | 80% | 80% |
| <b>Skilled Nursing Facility</b><br>90 days per calendar year maximum  | *   | 80% |
| <b>Special Equipment and Supplies</b>   | 80% | 80% |
| <b>Spinal Manipulations</b><br>10 spinal manipulations per calendar year                                      | 80% | 60% |
| <b>Temporomandibular Joint Disorders (TMJ)</b><br>\$1,000 per calendar year maximum; \$5,000 lifetime maximum | 80% | 60% |
| <b>Transplants</b><br>\$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:** \$2,500 per individual / \$5,000 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](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.**