



BreakThru 70 (\$1,000 or \$3,000 deductible) Online Application Instructions

- 1) After you are redirected to the Regence BlueShield website, review the statement and *click "Continue"*
- 2) Enter required zip code, gender, birth date, tobacco usage, and *click "Next"*
- 3) *Click "Apply"* on the BreakThru 70 (\$1,000 or \$3,000 deductible).
- 4) Review the plan information and *click "Apply"* again.
- 5) Enter the required account information including name, e-mail address, phone number, and challenge questions. *Click "Done"*
- 6) Create a username and password. *Click "Login"*
- 7) Review your selections and *click "Continue Your Application"*
- 8) Enter your complete address and all other required information.
- 9) Answer the "Yes" or "No" questions regarding your current or prior coverage.
- 10) Review your selections and *click "Done"*.
- 11) Choose to "Sign Electronically" (recommended) or mail in your paper application. *Click "Next"*
- 12) Affirm your information and enter your name twice. Click "Submit". On the following page *click "Next"*
- 13) The next section is the Standard Health Questionnaire. Review the parts and *click "Next"*
- 14) Click either "Yes" or "No" to the following questions. Clicking "Don't Know" will hold up your application. In most cases all of the answers are "No". *Click "Next"*.
- 15) Review your information and *click "Next"*
- 16) Review information about the SHQ and *click "Next"*
- 17) Enter phone number, height, weight, gender, and e-mail address. *Click "Next"*
- 18) Review medical questions and mark "Yes" or "No". If "Yes", provide additional information when prompted. *Click "Next"*

19) Repeat above procedure for all of the following sections.

20) Answer the following “Yes” or “No” Questions. *Click “Next”*

21) Click on “Use Electronic Signature”. Check the boxes and enter your name twice.
Click “Home”

Your Application has been received!

You will receive an email from Regence within 10 business days informing you of your Acceptance or Denial.

BreakThru 70 – PPO Network

\$1,000 or \$3,000 Deductible Options

Family deductible maximum is 3x individual deductible.
Benefits shown below are when you use a preferred provider.



Before the deductible is met:

These benefits are not subject to the deductible when you use a preferred provider.

- 1. Office visits – 100% after \$30 co-pay**
(Includes office, urgent care and naturopathy visits)
- 2. Preventive Care Exam is paid at 100% to \$200 per calendar year.**
(Routine Physical exam, immunizations, well child care and routine cancer screenings.)
30% co-insurance for mammograms, not subject to the deductible. Preventive diagnostic lab/x-ray services are not part of the \$200 limit, and you will pay 30% co-insurance after your deductible has been met.
- 3. Mental Health outpatient visits** (when billed as office visit for Rx maintenance)
\$30 co-pay (12 visit limit PCY)
- 4. Vision Care – (Participating Optical Provider)**
Routine Exam paid at 100% after \$30 co-pay. (one per calendar year)
Vision hardware is covered up to \$200 per calendar year, paid at 100%
- 5. Prescription Drugs – \$3,000 maximum** per person per calendar year (not subject to deductible)
Includes birth control pills and mental health drugs.
 - Tier 1 (Generic) = \$10 retail co-pay, \$20 co-pay for mail order (90 day supply)
 - Tier 2 (Brand Name Formulary) = 30% co-pay for retail or mail order
 - Tier 3 (Non-Formulary) = 50% co-pay for retail or mail order

After the deductible has been met, all other covered benefits are provided.

- **\$100 Emergency room co-pay** (waived if admitted), plus 30% co-insurance.
- **30% co-insurance for hospital and physician services** (preferred provider network)
- **\$5,000 annual co-insurance max.,** plus deductible and co-pays
(After you have met your deductible, you pay 30% of the next 16,666 (\$5,000 max), then Regence covers 100% of allowable charges up to 2 million)

- **2 million lifetime maximum**
- **Inpatient rehabilitation - \$4,000 PCY**
- **Outpatient rehabilitation – \$2,000 PCY**
(includes massage therapy)
- **Inpatient mental health – 8 days PCY**
- **Outpatient mental health – 12 visits PCY**
- **Includes 24 hour “on the job” coverage**
subscriber only (if not covered by L&I)
- **Includes maternity coverage**
- **Spinal manipulations, 10 PCY**
- **Acupuncture, 12 PCY**

Partial list of Exclusions:
chemical dependency, TMJ.

AGE BAND	\$1,000 Deductible		\$3,000 Deductible	
	NON-SMOKER	SMOKER	NON-SMOKER	SMOKER
<25	\$175	\$203	\$113	\$132
25-29	\$202	\$231	\$131	\$150
30-34	\$235	\$270	\$153	\$178
35-39	\$277	\$318	\$180	\$208
40-44	\$327	\$381	\$215	\$249
45-49	\$397	\$458	\$262	\$300
50-54	\$471	\$542	\$305	\$355
55-59	\$554	\$638	\$362	\$417
60-64	\$653	\$759	\$422	\$495
Per Child	\$162		\$108	
2nd Child	\$307		\$203	

*This flyer was prepared by the Health Insurance Connection, Inc. This is a brief summary of benefits and is not a certificate of coverage. For full coverage provisions, including a description of waiting periods and limitations, refer to a benefit brochure and contract. This summary is not a contract. Rates guaranteed until August 1, 2010.

SUMMARY OF BENEFITS
REGENCE BREAKTHRU 70
(A PREFERRED PLAN)



Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

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 copays and coinsurance.

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 for the services of Preferred Plan providers only, unless otherwise specified. Any balances of charges not covered by this plan will be your responsibility to pay.

The annual deductible, copays, prescription drugs, outpatient rehabilitation, vision hardware, and most participating provider services do not apply to the annual out-of-pocket coinsurance amount.

Benefits	Preferred Plan Provider	Participating Provider
Annual Deductible Copays, prescription drugs, preventive care, and the routine eye exam do not count toward the deductible. Family deductible is met when three or more covered family members reach the equivalent of three individual deductible amounts in a calendar year	\$1,000 per individual/\$3,000 per family or \$3,000 per individual/\$9,000 per family	
Lifetime maximum	\$2,000,000 per individual	
Annual Out-of-Pocket Coinsurance Amount Family out-of-pocket coinsurance amount is met when three or more covered family members reach the equivalent of three individual out-of-pocket coinsurance amounts in a calendar year	\$5,000 per person \$15,000 per family	No out-of-pocket maximum
Professional Services Visits in the office, home, and outpatient hospital; not subject to deductible Outpatient diagnostic x-ray and laboratory services; and other professional services; subject to deductible Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers	(unless specified otherwise)	
	100% after \$30 per-visit copay	100% after \$40 per-visit copay
	70%	50%
Hospital Facility (Inpatient and Outpatient)**** Including diagnostic x-ray and laboratory \$100 copay per emergency room visit (waived if admitted)	70%	50%
Acupuncture 12 visits per calendar year maximum	70%	50%
Ambulance Services** Ground services: \$2,000 per calendar year maximum	70%	70%
Blood Bank**	70%	70%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	70%	70%
Home Medical Equipment \$2,500 per calendar year maximum	70%	50%
Home Phototherapy	70%	70%
Infusion Therapy Growth hormone treatment is limited to \$25,000 per calendar year	70%	50%
Mammography Routine mammograms not subject to deductible	70%	50%
Maternity	70%	50%
Mental Disorders Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	70%	50%
Occupational Injury (provided for the subscriber only)	same as any condition	
Phenylketonuria (PKU) Formulas Not subject to waiting periods	70%	70%

Prescription Drugs		
\$3,000 per calendar year maximum; not subject to deductible		
Generic Formulary	100% after \$10 Retail copay / 100% after \$20 Mail Order copay	
Brand-Name Formulary		70%
Non-Formulary		50%
Preventive Care	70%	50%
\$200 per calendar year maximum; not subject to deductible		
Routine exams, immunizations, well child care, and routine cancer screenings including preventive surgeries (routine colorectal cancer screenings not subject to maximum)		
Prostate Cancer Screening	70%	50%
Routine prostate cancer screenings not subject to deductible		
Prostheses and Orthotics	70%	50%
Rehabilitation	70%	50%
Inpatient – \$4,000 per calendar year maximum		
Outpatient – \$2,000 per calendar year maximum		
Skilled Nursing Facility	*	70%
30 days per calendar year maximum		
Special Equipment and Supplies	70%	70%
Spinal Manipulations	70%	50%
10 manipulations per calendar year maximum		
Transplants	70%	50%
\$350,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum; 12-month waiting period		
Vision Care (not subject to deductible)		
One routine eye exam per calendar year	100% after \$30 copay	100% after \$40 copay
Vision hardware: \$200 per calendar year maximum for all providers	***	100%

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

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

***At this time, this service is provided only by participating or recognized optical providers.

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

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.

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.

Copay: There is a 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.

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 (2583) 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 or call collect at 1-804-673-1177. If you are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours to receive full plan benefits. If you meet all requirements, inpatient benefits will be provided at the level specified for Preferred Plan providers for like services and supplies.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this plan for 12 consecutive months. This waiting period will be reduced by any time that you were covered under prior plan(s) that qualify as creditable coverage. No benefits will be provided for preexisting conditions, including postnatal treatment of pregnancy, delivery, and voluntary termination of pregnancy, until you have been covered under this plan for nine consecutive months, unless you were continuously covered for at least nine months under the immediately preceding creditable 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 the plan contract. 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 EXCLUSIONS INDIVIDUAL PLANS



Regence BlueShield is an Independent Licensee
of the Blue Cross and Blue Shield Association

Exclusions and Limitations to Coverage: The noncovered services and supplies under our standard medical plans include, but are not limited to:

- Acupuncture for smoking cessation.
- Addiction to or abuse of drugs, alcohol, or any other chemical substance, whether legal or illegal, except for injuries sustained as a consequence of being intoxicated or under the influence of narcotics.
- Benefits covered by government programs.
- Charges for services or supplies that are above the allowed amount, except as required by law for emergencies.
- Charges that in the absence of the contract there would be no obligation to pay.
- Cosmetic surgery and supplies (including drugs) and the treatment of any direct or indirect complications of such surgery, except: 1) when related to an illness or injury; 2) for congenital anomalies; 3) for reconstructive breast surgery following mastectomies to the extent required under federal and state law as follows: a) reconstruction of the diseased breast; b) reconstruction of the nondiseased breast to produce a symmetrical appearance; and c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas.
- Custodial care.
- Dentistry, dental x-rays, or hospitalization for dentistry.
- Dyslexia treatment.
- Home medical equipment (*excluded on Selections[®] 80/50/15 only*).
- Hospitalization for conditions for which the member is not usually hospitalized, such as common colds, minor cuts or bruises, removal of small tumors and similar minor conditions.
- Injuries sustained while practicing for or competing in professional or semiprofessional athletics contest.
- Inpatient rehabilitative care (*excluded on Selections plans only*).
- Investigational services or supplies.
- In-vitro fertilization, artificial insemination, embryo transfer, or other artificial means of conception, including any expenses for fertility drugs.
- Marital counseling; family counseling, except for Mental Disorders.
- Maternity/complications of pregnancy (*excluded on Selections Catastrophic, PPO Catastrophic, HSA-Qualified Preferred Catastrophic, Regence HSA Healthplan, Regence NowSelectSM, and Regence Breakthru 50 plans only*).
- Neurodevelopmental therapy.
- Occupational injury or disease (*excluded on Selections plans, PPO Comprehensive, PPO Catastrophic, and HSA-Qualified Preferred Catastrophic plans only*).
- Over-the-counter contraceptive supplies and devices.
- Physical or psychiatric exams to obtain or continue employment, licensure, legal proceedings, insurance, school admission, sports activities, or for purposes of medical research.
- Prescription drugs, except as provided to an inpatient (*excluded on Selections Catastrophic, PPO Catastrophic, HSA-Qualified Preferred Catastrophic, Regence HSA Healthplan, Regence NowSelect, and Regence Breakthru 50 plans only*).
- Preventive care, except for routine mammography, prostate, and colorectal cancer screening services (*excluded on Selections Catastrophic, PPO Catastrophic, and Regence Breakthru 50 plans only*).
- Private duty nursing or hourly nursing charges.
- Routine hearing exams, hearing aids.
- Routine newborn care, except for the subscriber's natural newborn or newly adoptive child added as a dependent within 60 days of birth or placement (*excluded on Selections Catastrophic, PPO Catastrophic, HSA-Qualified Preferred Catastrophic, Regence HSA Healthplan, Regence NowSelect, and Regence Breakthru 50 plans only*).
- Services or supplies covered by auto insurance, personal injury protection insurance, homeowner insurance, or commercial premises coverage.
- Services or supplies not medically necessary* for illness, injury, or physical disability.
- Services provided by a family member (spouse, parent, or child).
- Smoking cessation (*excluded on HSA-Qualified Preferred Catastrophic, Regence HSA Healthplan, Regence HSA Healthplan Comprehensive, Regence NowSelect, and Regence Breakthru plans only*).
- Sterilization.
- Surgery (including reversals), treatment, programs, or supplies that are intended to result in weight reduction, regardless of diagnosis.
- Surgery or treatment for sexual dysfunction/impotence or transsexualism.
- Treatment and any appliances used in connection with malocclusions, jaw abnormalities, Temporomandibular Joint Disorders, and myofascial pain syndrome.
- Treatment of any condition caused by or resulting from active participation in the armed forces in a war or insurrection.
- Treatment of any condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.
- Vision exams and hardware (*excluded on Selections plans, PPO Catastrophic, HSA-Qualified Preferred Catastrophic, Regence HSA Healthplan, Regence HSA Healthplan Comprehensive, Regence NowSelect, and Regence Breakthru 50 plans only*).
- Visits or consultations that are not in person, including but not limited to any telephone, Internet, or other electronic communication (except tele-medicine in remote locations, as approved by the Company), whether initiated by the member or the member's provider.
- Visual analysis, therapy, training, or orthoptics.

***Medically Necessary:** Health care services or supplies that a physician or other health care provider exercising prudent clinical judgment, would provide to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are: In accordance with generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease; and not primarily for the convenience of you, or your physician or other health care provider, and not more costly than an alternative service or sequence of services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of the physicians practicing in relevant clinical areas and other relevant factors.

This is a brief summary of exclusions and limitations; it is not a certificate of coverage. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, refer to the plan contract. 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.