Regence Individual Direct Plan Highlights
Gold 1000, Silver 3000, Bronze Essential 6850
1/1/2016

Regence

Plan Information

- Provider networks: Members have direct access to their choice of providers. Member cost-sharing is lowest for In-Network providers. If a member chooses an Out-of-Network provider, the member may be required to pay costs above the allowed amount.
- Ambulatory Surgical Center: While many surgical procedures are best performed in a hospital setting, many can be safely and effectively performed in an Ambulatory Surgery Center (ASC) at a lower cost. If your doctor recommends that you have one of these surgeries, you may pay less out-of-pocket if you choose to have it performed at an ASC. For more information, or a list of services that can be performed at an ASC, contact Regence customer service.
- Telehealth visits (conducted via phone, secure online video, mobile app or web) for primary care services are available.
- Separate deductible and separate out-of-pocket maximum amounts per calendar year for In-Network and Out-of-Network providers. The calendar year deductible and out-of-pocket maximum applies to all covered expenses except where noted. When the out-of-pocket maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year.
- Member responsibility for In-Network services is indicated below, after In-Network deductible is met and until out-of-pocket maximum is met, except where noted. Member responsibility for Out-of-Network services is 50% Gold 1000 , Silver 3000 and 0% Bronze Essential 6850 after Out-of-Network deductible is met and until out-of-pocket maximum is met, except where noted.

Calendar Year Deductible

In-Network	**Gold 1000**	**Silver 3000**	**Bronze Essential 6850**
Individual/Family	$1,000/$2,000	$3,000/$6,000	$6.850/$13,700
Out-of-Network	**Gold 1000**	**Silver 3000**	**Bronze Essential 6850**
Individual/Family	$5,000/$10,000	$10,000/$20,000	$13,700/$27,400

Calendar Year Out-of-Pocket Maximum

In-Network	**Gold 1000**	**Silver 3000**	**Bronze Essential 6850**
Individual/Family	$4,700/$9,400	$6,850/$13,700	$6,850/$13,700
Out-of-Network	**Gold 1000**	**Silver 3000**	**Bronze Essential 6850**
Individual/Family	$9,400/$18,800	$13,700/$27,400	$13,700/$27,400

10 Essential Health Benefits - Covered Services

Be aware that the members' actual costs for covered services provided by an out-of-network provider may exceed the contracts out-of-network out-of-pocket maximum amount. The members' costs for specialty medications do not accumulate toward any out-of-pocket maximum amount if delivered by a nonparticipating specialty pharmacy. In addition, out-of-network providers and nonparticipating specialty pharmacies can bill the member for the difference between the amount charged and our allowed amount and that amount does not count toward any out-of-pocket maximum.

1. Ambulatory Patient Services

(Outpatient Care)

	In-Network Member Responsibility		
	Gold 1000	**Silver 3000**	**Bronze Essential 6850**
Office Visits	Primary care: Not subject to deductible $30 copay Specialist Care: $50 copay Urgent Care: $50 copay	Primary care: Not subject to deductible $30 copay Specialist Care: $50 copay Urgent Care: $50 copay	Primary care: 2 upfront visits at $40 copay, then 0% after deductible Specialist Care: 0% after deductible Urgent Care: 0% after deductible
Ambulatory Surgical Center services and supplies	10%	10%	0%
Hospital outpatient services and supplies	20%	20%	0%
Complex Outpatient Imaging (CTs, MRIs, PETs)	20%	20%	0%

2. Emergency Services

In-Network benefits apply regardless of provider network

	Gold 1000	**Silver 3000**	**Bronze Essential 6850**
Emergency Room	20%	20%	0%
Ambulance	20%	20%	0%

3. Hospitalization	Gold 1000	Silver 3000	Bronze Essential 6850
Inpatient services and supplies	20%	20%	0%

4. Maternity and Newborn Care	Gold 1000	Silver 3000	Bronze Essential 6850
Pregnancy care, childbirth and complications of pregnancy, and Newborn Care	20%	20%	0%

5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment	Gold 1000	Silver 3000	Bronze Essential 6850
Inpatient Services	20%	20%	0%
Outpatient Services	20%	20%	0%

6. Prescription Medications[1]	Gold 1000	Silver 3000	Bronze Essential 6850
Calendar Year Deductible In-Network medical deductible applies unless otherwise specified	Medical deductible waived for Tier 1	Medical deductible waived for Tier 1	Medical deductible waived for Tier 1
Tier 1: Generics (Category 1)	$10 Retail / $20 Mail	$10 Retail / $20 Mail	$20 Retail / $40 Mail
Tier 2: Generics (Category 2) and Brand Name (Category 1)	30% Retail / 25% Mail	30% Retail / 25% Mail	$0 Retail / $0 Mail
Tier 3: Brand Name (Category 2)	50% Retail / 40% Mail	50% Retail / 40% Mail	0% Retail / 0% Mail
Tier 4: Specialty Medications	40%	40%	0%

[1] All out-of-pocket expenses go towards In-Network Medical Out-of-Pocket Maximum. Essential Formulary applies to all plans. Members can receive a $5 or 5% discount for prescription medications at Preferred Pharmacies.

Retail: Up to 90-day supply for Tiers 1, 2 and 3.

Mail-Order: Up to 90-day supply. Specialty Medications: Covered at participating retail pharmacies for first fill only. After first fill members use specialty pharmacies. Up to 30-day supply per fill. Self- Administrable Cancer Chemotherapy: Members use specialty pharmacies. Up to 30-day supply per fill.

7. Rehabilitative and Habilitative Services and Devices	Gold 1000	Silver 3000	Bronze Essential 6850
Rehabilitation Services (Inpatient) includes Habilitative Services	20%	20%	0%
Rehabilitation and Habilitative Services (Outpatient) • 20 visits per calendar year	20%	20%	0%
Durable Medical Equipment	20%	20%	0%

8. Laboratory Services	Gold 1000	Silver 3000	Bronze Essential 6850
Outpatient Radiology and Laboratory and Diagnostic imaging including X-rays (Complex Outpatient Imaging refer to Ambulatory Patient Services)	20%	20%	0%

9. Preventive Services	Gold 1000	Silver 3000	Bronze Essential 6850
In-Network not subject to deductible	0%	0%	0%

10. Pediatric Services	Gold 1000	Silver 3000	Bronze Essential 6850
Pediatric Dental • Various limits apply • Covered for members up to age 19 • Member responsibility indicated is for both in-Network / Out-of-Network services	Preventive: 0% / Basic: 20% / Major: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Preventive: 0% / Basic: 20% / Major: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Preventive: 0% / Basic: 20% / Major: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum
Pediatric Vision • Covered for members up to age 19 • Member responsibility indicated is for both in-Network / Out-of-Network services • One routine eye exam per calendar year • One pair (two lenses) and one standard frame per calendar year • Contacts in lieu of glasses	Eye exam: 0% / Vision Hardware: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Eye exam: 0% / Vision Hardware: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Eye exam: 0% / Vision Hardware: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum

Other Covered Services	Gold 1000	Silver 3000	Bronze Essential 6850
Spinal Manipulations • 18 spinal manipulations per calendar year	20%	20%	0%

Additional Information	All Plans
Preventive Services	Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings. Also included is provider counseling for tobacco use cessation and generic medications prescribed for tobacco use cessation. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time). Additionally, We cover all United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants and surgical sterilization.
Outside the Service Area	Members have the security of knowing they can access Blue Cross and/or Blue Shield (Blue Plan) providers across the country and worldwide through the BlueCard® Program. Plan benefits apply as described within this document, and members may receive discounts on their services.

Questions and Answers

How do I find out more about the providers available in my network?	• You can visit www.regence.com/find-a-doctor to search for providers in your network. • The network available is Preferred PPO.
Do I need to select a Primary Care Provider (PCP)?	• No
What if I need to access care after hours, or if my regular provider's office is closed?	• If you are experiencing a medical emergency, you should call 911. If your medical situation is urgent, and you do not feel you can wait to see your regular provider, you can visit www.regence.com/find-a-doctor to search for urgent care or emergency care services.
What if I need access to specialty care? Do I need a referral?	• You can receive care from any in-network provider without a referral. For some services, prior authorization may be required.
What if I need information in another language?	• If you need help obtaining this information in other languages, please contact our Customer Service number at 1-800-541-8981 for additional information. (TTY users should call 711). Hours are 8:00 a.m. to 8:00 p.m., Monday through Friday (from October 1 through February 14, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week). • *Esta información se encuentra disponible gratis en otros idiomas. Comuníquese con nuestro Servicios para Miembros al 1-800-541-8981 para obtener información adicional. Los usuarios de TTY deben llamar al 711. Las horas de atención son de 8:00 a.m. a 8:00 p.m., de lunes a viernes (del 1 de octubre al 14 de febrero, nuestro horario telefónico es de 8:00 a.m. a 8:00 p.m., siete días a la semana).*
How is my privacy protected?	• Regence is committed to the confidentiality and security of your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information. • You can view our full privacy practices online at https://www.regence.com/web/regence_individual/privacy-practices

General Medical Exclusions

	Coverage is not provided for any of the following, including direct complications or consequences that arise from:
Acupuncture	
Applied Behavioral Analysis Therapy	
Breast Reduction	Except when following a Medically Necessary mastectomy, to the extent required by law, We do not cover breast reductions.
Conditions Caused By Active Participation In a War or Insurrection	The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.
Conditions Incurred In or Aggravated During Performances In the Uniformed Services	The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of services in the uniformed services of the United States.
Cosmetic/Reconstructive Services and Supplies	Except to treat a congenital anomaly for members up to age 26, to restore a physical bodily function lost as a result of injury or illness or related to breast reconstruction following a medically necessary mastectomy, to the extent required by law.
Counseling in the absence of illness	Except as provided in the Policy or as required by law, We do not cover counseling in the absence of Illness, for example: educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Individual Assistance Program ("IAP") services, except as specifically provided under the IAP Section, if applicable; wilderness programs; premarital or marital counseling; and family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits).
Custodial Care	Except as provided under the Palliative Care benefit in the Policy, We do not cover non-skilled care and helping with activities of daily living.
Dental Services	Except as provided in the Policy, We do not cover Dental Services provided to prevent, diagnose, treat diseases, or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.
Elective Abortions	We do not cover elective abortions. Coverage for non-elective abortions is provided under the Termination of Pregnancy benefit in the policy.
Facilities Without a Provider Legally Required to be on Duty	Admission and treatment in a setting where neither a Physician, Practitioner, nor licensed nurse is legally required to be on duty at all times that a patient is admitted.

Fees, Taxes, Interest	Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.
Government Programs	Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the Service Area (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).
Hearing Care	Routine hearing examinations, programs or treatment for hearing loss including hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.
Infertility	Treatment of infertility, except to the extent covered services are required to diagnose such condition. Non-covered treatment includes, but is not limited to, all assisted reproductive technologies (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), fertility drugs and medications, and other artificial means of conception.
Investigational Services	Except as provided under the Approved Clinical Trials benefit in the Policy, We do not cover Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol.
Mental Health Treatment For Certain Conditions	We do not cover Mental Health Conditions for treatment of paraphilias or paraphilic disorders (except gender identity disorder in children or gender identity disorder in adolescents or adults). Additionally, We do not cover any V code diagnoses, except for Medically Necessary treatment for children ages five and under for parent-child problems, neglect, abuse or bereavement. By "V code," We mean codes for additional conditions that may be a focus of clinical attention, as described in the most recent edition of the DSM, that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment. This includes, but is not limited to, such issues as occupational or academic problems.

Motor Vehicle Coverage and Other Available Insurance	Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), or automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Coordination of Benefits provision of the Policy shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Member, whether or not the Member makes a claim under such coverage. Further, the Member is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, We will provide benefits according to the Policy.
Non-Direct Patient Care	Including appointments scheduled and not kept ("missed appointments"), charges for preparing or duplicating medical reports and chart notes, itemized bills or claim forms (even at Our request) and visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as provided under the Telehealth and Telemedicine benefits.
Obesity or Weight Reduction/Control	Except as provided in the Policy , We do not cover medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions. This exclusion does not apply to reversals or revisions of surgery for obesity when required to correct a life-endangering condition. This exclusion also does not apply to treatment of obesity-related comorbid medical conditions; for example: diabetes, high blood pressure and heart disease.
Orthognathic Surgery	Services and supplies for orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to an Injury, sleep apnea, or Congenital Anomaly.
Over the Counter Contraceptives	Except as provided under the Prescription Medications benefit, We do not cover over-the-counter contraceptive supplies.
Personal Comfort Items	Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes.
Physical Exercise Programs and Equipment	Including hot tubs or membership fees at spas, health clubs, or other such facilities. This exclusion applies even if the program, equipment, or membership is recommended by the member's provider.
Private Duty Nursing	Private-duty nursing, including ongoing shift care in the home.
Reversal of Sterilizations	Services and supplies related to reversal of sterilization.

Riot, Rebellion and Illegal Acts	Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection, or rebellion or sustained by a member arising directly from an act deemed illegal by an officer or a court of law.
Routine Foot Care	
Self-Help, Self-Care, Training, or Instructional Programs	Self-help, non-medical self-care, training programs, including: diet and weight monitoring services; childbirth-related classes including infant care and breast feeding classes; and instruction programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member. This exclusion does not apply to services for training or educating a Member when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service in the Policy (for example, nutritional counseling and diabetic education).
Services and Supplies Provided by a Member of Your Family	Services and supplies provided to you by a member of your immediate family. For purposes of this provision, "immediate family" means you and your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings; your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings; your child's or stepchild's spouse or domestic partner; and any other of your relatives by blood, marriage or who shares a residence with you.
Services and Supplies That Are Not Medically Necessary	Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury, except for preventive care benefits specifically provided in the Policy.
Sexual Dysfunction	Except for counseling services provided by covered, licensed Practitioners, we do not cover services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.
Sexual Reassignment Surgery	
Temporomandibular Joint (TMJ) Disorder Treatment	Services and supplies provided for temporomandibular joint (TMJ) disorder treatment.
Third-Party Liability	Services and supplies for treatment of illness or injury for which a third party is or may be responsible.
Tobacco Addiction Treatment	Except as specifically provided in the Policy, We do not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes
Travel and Transportation Expenses	Travel and transportation expenses other than covered ambulance services or as otherwise specifically provided in the Policy.

Vision Care	Except as provided in the Policy we do not cover routine eye exam and vision hardware. We also do not cover visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.
Work-Related Conditions	Expenses for services and supplies incurred as a result of any work-related injury or illness, including any claims that are resolved related to a disputed claim settlement. We may require you or one of your eligible dependents to file a claim for workers' compensation benefits before providing any benefits under the Policy. We do not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if you or one of your eligible dependents are exempt from state or federal workers' compensation law.

General Pharmacy Exclusions

Biological Sera, Blood, or Blood Plasma	
Brand-Name Medications not on the Essential Formulary	Except as provided through the Substitution Process in the Prescription Medications benefit, We do not cover Prescription Medications for Brand-Name Medications that are not on the Essential Formulary list.
Cosmetic Purposes	Prescription medications used for cosmetic purposes including removal, inhibition or stimulation of hair growth, retardation of aging or repair of sun-damaged skin.
Devices or Appliances	Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Durable Medical Equipment benefit).
Foreign Prescription Medications	Except those associated with an emergency medical condition while you are traveling outside the United States, or those you purchase while residing outside the United States. We do not cover Foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.
Insulin Pumps and Pump Administration Supplies	Coverage for insulin pumps and supplies is provided under the Diabetic Supplies and Equipment benefit.
Medications We Don't Consider Self-Administrable	Coverage for these medications may otherwise be provided under the Medical Benefits Section.
Nonprescription Medications	Medications that by law do not require a prescription order and which are not included in Our definition of Prescription Medications, unless included on Our Essential Formulary.

Prescription Medications Dispensed in a Facility	Prescription medications dispensed to you while you are a patient in a hospital, skilled nursing facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.
Prescription Medications For Treatment of Infertility	
Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order	
Prescription Medications Not within a Provider's License	Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.
Prescription Medications Used for Sexual Dysfunction or Enhancement	
Prescription Medications Without Examination	Except as provided under the Telehealth and Telemedicine benefits in this Medical Benefits Section, we do not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.
Professional Charges for Administration of Any Medication	
Travel Immunizations	Immunizations for the purposes of travel, occupation or residency in a foreign country.

General Pediatric Dental Exclusions

Adjustments	Adjustment of a denture or bridgework which is done within 6 months after insertion by the same Dentist who installed the denture or bridgework.
Aesthetic Dental Procedures	Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth.

Bone Grafts	Bone grafts done in connection with extractions, apicoectomies or non-covered/ineligible implant.
Cone Beam Imaging/MRI Procedures	
Cosmetic/Reconstructive Services and Supplies	Cosmetic and/or reconstructive services and supplies, except for Dentally Appropriate services and supplies to treat a Congenital Anomaly and to restore a physical bodily function lost as a result of Injury or Illness.
Decay Prevention	Supplies and materials to prevent decay, such as toothpaste, fluoride gels, dental floss, and teeth whiteners.
Duplicate Services	Services submitted by a Dentist which are for the same services performed on the same date for the same Member by another Dentist.
Experimental or Investigational Services	
Fabrication of Athletic Mouth Guard	
Facility Expenses	Services and supplies related to facility expenses, including, but not limited to: those performed by a Dentist who is compensated by a facility for similar Covered Services performed for Member; and costs or any additional fees that the Dentist or Hospital charges for treatment at the Hospital (inpatient or outpatient).
Failure to Comply	Services and supplies resulting from Your failure to comply with professionally prescribed treatment.
Gold-Foil Restorations	
Oral Sedation	
Nitrous Oxide	
Oral Hygiene and Dietary Instructions	
Orthodontic Dental Services	Except when Dentally Appropriate, We will not cover services and supplies provided in connection with orthodontics, including the following: correction of malocclusion; craniomandibular orthopedic treatment; other orthodontic treatment; preventive orthodontic procedures; procedures for tooth movement, regardless of purpose; and repair of damaged orthodontic appliances.
Plaque Control Programs	
Precision Attachments, Precious Metal Bases and Other Specialized Techniques	

Provisional, Temporary and Duplicate Devices or Appliances	
Replacements	Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.
Sealants	Except as provided for permanent molars.
Separate Charges	Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following: any supplies; local anesthesia; and sterilization (office infection control charges).
Services and Supplies to Alter Vertical Dimension and/or Restore or Maintain the Occlusion	Services and supplies to alter vertical dimension and/or restore or maintain the occlusion, including the following: equilibration; periodontal splinting; full mouth rehabilitation; and restoration for misalignment of teeth.
Services and Supplies Which the Insured Would Have No Legal Obligation to Pay in the Absence of this Coverage	
Services Provided by Certain Entities	Services and treatment received from a Dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration Hospital or similar person or group.
Specialized Procedures and Techniques	
Temporomandibular Joint (TMJ) Disorder Treatment	Services and supplies provided in connection with temporomandibular joint (TMJ) disorder.
Topical Medicament Center	

This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. For full coverage provisions, refer to the contract.

Regence Individual Direct Pediatric Dental Plan Highlights
Gold 1000, Silver 3000, Silver HSA 2500, Bronze HSA 5000, Bronze Essential 6850
1/1/2016

Regence

Plan Features

- Pediatric Dental coverage for members up to age 19.
- Member's coinsurance amounts apply to In-Network medical out-of-pocket maximum.
- The following Pediatric Dental benefits are embedded in the Gold 1000, Silver 3000, Silver HSA 2500, Bronze HSA 5000 and Bronze Essential 6850 plans.

Calendar Year Deductible

Deductible waived on all services

Be aware out-of-network providers can bill the member for the difference between the amount charged and our allowed amount and that amount does not count toward any out-of-pocket maximum.

Covered Services (per member)

Preventive and Diagnostic Services	Member Responsibility In-Network/Out-of-Network
X-rays: • Bitewing x-ray series: 2 per calendar year • Complete intra-oral mouth x-rays: once in a 3-year period **Cleanings:** 2 per calendar year **Oral examinations:** • Preventive: 2 per calendar year • Diagnostic: 2 per calendar year **Topical fluoride application:** 2 treatments per calendar year **Sealants (permanent molars):** once per tooth in a 3-year period **Space maintainers**	**0%**

Basic Services	
Fillings: Consisting of composite and amalgam restorations **Oral Surgery:** Uncomplicated and complex oral surgery procedures **General dental anesthesia or intravenous sedation:** Subject to necessity **Emergency treatment for pain relief** **Periodontal Maintenance:** 4 per calendar year (in lieu of preventive cleanings) **Scaling and Root Planing:** Once in a 2-year period per quadrant **Endodontic services** including root canal treatment, pulpotomy and apicoectomy	**20%**
Major Services	
Crowns, inlays and onlays: once in a 7-year period (no limit for stainless steel crowns) **Dental implants:** 4 per member lifetime **Dentures (full or partial):** once in a 5-year period **Bridges (fixed partial denture):** once in a 5-year period **Orthodontia:** Covered when medically necessary	**50%**

General Medical Exclusions	Coverage is not provided for any of the following, including direct complications or consequences that arise from:
Acupuncture	
Applied Behavioral Analysis Therapy	
Breast Reduction	Except when following a Medically Necessary mastectomy, to the extent required by law, We do not cover breast reductions.
Conditions Caused By Active Participation In a War or Insurrection	The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.
Conditions Incurred In or Aggravated During Performances In the Uniformed Services	The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of services in the uniformed services of the United States.
Cosmetic/Reconstructive Services and Supplies	Except to treat a congenital anomaly for members up to age 26, to restore a physical bodily function lost as a result of injury or illness or related to breast reconstruction following a medically necessary mastectomy, to the extent required by law.
Counseling in the absence of illness	Except as provided in the Policy or as required by law, We do not cover counseling in the absence of Illness, for example: educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Individual Assistance Program ("IAP") services, except as specifically provided under the IAP Section, if applicable; wilderness programs; premarital or marital counseling; and family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits).
Custodial Care	Except as provided under the Palliative Care benefit in the Policy, We do not cover non-skilled care and helping with activities of daily living.
Dental Services	Except as provided in the Policy, We do not cover Dental Services provided to prevent, diagnose, treat diseases, or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.
Elective Abortions	We do not cover elective abortions. Coverage for non-elective abortions is provided under the Termination of Pregnancy benefit in the Policy.
Facilities Without a Provider Legally Required to be on Duty	Admission and treatment in a setting where neither a Physician, Practitioner, nor licensed nurse is legally required to be on duty at all times that a patient is admitted.
Fees, Taxes, Interest	Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Government Programs	Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the Service Area (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).
Hearing Care	Routine hearing examinations, programs or treatment for hearing loss including hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.
Infertility	Treatment of infertility, except to the extent covered services are required to diagnose such condition. Non-covered treatment includes, but is not limited to, all assisted reproductive technologies (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), fertility drugs and medications, and other artificial means of conception.
Investigational Services	Except as provided under the Approved Clinical Trials benefit in the Policy, We do not cover Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol.
Mental Health Treatment For Certain Conditions	We do not cover Mental Health Conditions for treatment of paraphilias or paraphilic disorders (except gender identity disorder in children or gender identity disorder in adolescents or adults). Additionally, We do not cover any V code diagnoses, except for Medically Necessary treatment for children ages five and under for parent-child problems, neglect, abuse or bereavement. By "V code," We mean codes for additional conditions that may be a focus of clinical attention, as described in the most recent edition of the DSM, that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment. This includes, but is not limited to, such issues as occupational or academic problems.
Motor Vehicle Coverage and Other Available Insurance	Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), or automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Coordination of Benefits provision of the Policy shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Member, whether or not the Member makes a claim under such coverage. Further, the Member is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, We will provide benefits according to the Policy.

Non-Direct Patient Care	Including appointments scheduled and not kept ("missed appointments"), charges for preparing or duplicating medical reports and chart notes, itemized bills or claim forms (even at Our request) and visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as provided under the Telehealth and Telemedicine benefits.
Obesity or Weight Reduction/Control	Except as provided in the Policy , We do not cover medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions. This exclusion does not apply to reversals or revisions of surgery for obesity when required to correct a life-endangering condition. This exclusion also does not apply to treatment of obesity-related comorbid medical conditions; for example: diabetes, high blood pressure and heart disease.
Orthognathic Surgery	Services and supplies for orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to an Injury, sleep apnea, or Congenital Anomaly.
Over the Counter Contraceptives	Except as provided under the Prescription Medications benefit, We do not cover over-the-counter contraceptive supplies.
Personal Comfort Items	Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes.
Physical Exercise Programs and Equipment	Including hot tubs or membership fees at spas, health clubs, or other such facilities. This exclusion applies even if the program, equipment, or membership is recommended by the member's provider.
Private Duty Nursing	Private-duty nursing, including ongoing shift care in the home.
Reversal of Sterilizations	Services and supplies related to reversal of sterilization.
Riot, Rebellion and Illegal Acts	Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection, or rebellion or sustained by a member arising directly from an act deemed illegal by an officer or a court of law.
Routine Foot Care	
Self-Help, Self-Care, Training, or Instructional Programs	Self-help, non-medical self-care, training programs, including: diet and weight monitoring services; childbirth-related classes including infant care and breast feeding classes; and instruction programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member. This exclusion does not apply to services for training or educating a Member when provided without separate charge in connection with Covered Services or when specifically indicated as a

	Covered Service in the Policy (for example, nutritional counseling and diabetic education).
Services and Supplies Provided by a Member of Your Family	Services and supplies provided to you by a member of your immediate family. For purposes of this provision, "immediate family" means you and your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings; your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings; your child's or stepchild's spouse or domestic partner; and any other of your relatives by blood, marriage or who shares a residence with you.
Services and Supplies That Are Not Medically Necessary	Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury, except for preventive care benefits specifically provided in the Policy.
Sexual Dysfunction	Except for counseling services provided by covered, licensed Practitioners, we do not cover services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.
Sexual Reassignment Surgery	
Temporomandibular Joint (TMJ) Disorder Treatment	Services and supplies provided for temporomandibular joint (TMJ) disorder treatment.
Third-Party Liability	Services and supplies for treatment of illness or injury for which a third party is or may be responsible.
Tobacco Addiction Treatment	Except as specifically provided in the Policy, We do not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes
Travel and Transportation Expenses	Travel and transportation expenses other than covered ambulance services or as otherwise specifically provided in the Policy.
Vision Care	Except as provided in the Policy we do not cover routine eye exam and vision hardware. We also do not cover visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.
Work-Related Conditions	Expenses for services and supplies incurred as a result of any work-related injury or illness, including any claims that are resolved related to a disputed claim settlement. We may require you or one of your eligible dependents to file a claim for workers' compensation benefits before providing any benefits under the Policy. We do not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if you or one of your eligible dependents are exempt from state or federal workers' compensation law.
General Pharmacy Exclusions	
Biological Sera, Blood, or Blood Plasma	

Brand-Name Medications not on the Essential Formulary	Except as provided through the Substitution Process in the Prescription Medications benefit, We do not cover Prescription Medications for Brand-Name Medications that are not on the Essential Formulary list.
Cosmetic Purposes	Prescription medications used for cosmetic purposes including removal, inhibition or stimulation of hair growth, retardation of aging or repair of sun-damaged skin.
Devices or Appliances	Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Durable Medical Equipment benefit).
Foreign Prescription Medications	Except those associated with an emergency medical condition while you are traveling outside the United States, or those you purchase while residing outside the United States. We do not cover Foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.
Insulin Pumps and Pump Administration Supplies	Coverage for insulin pumps and supplies is provided under the Diabetic Supplies and Equipment benefit.
Medications We Don't Consider Self-Administrable	Coverage for these medications may otherwise be provided under the Medical Benefits Section.
Nonprescription Medications	Medications that by law do not require a prescription order and which are not included in Our definition of Prescription Medications, unless included on Our Essential Formulary.
Prescription Medications Dispensed in a Facility	Prescription medications dispensed to you while you are a patient in a hospital, skilled nursing facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.
Prescription Medications For Treatment of Infertility	
Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order	
Prescription Medications Not within a Provider's License	Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.
Prescription Medications Used for Sexual Dysfunction or Enhancement	
Prescription Medications Without Examination	Except as provided under the Telehealth and Telemedicine benefits in this Medical Benefits Section, we do not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it

	involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.
Professional Charges for Administration of Any Medication	
Travel Immunizations	Immunizations for the purposes of travel, occupation or residency in a foreign country.

General Pediatric Dental Exclusions

Adjustments	Adjustment of a denture or bridgework which is done within 6 months after insertion by the same Dentist who installed the denture or bridgework.
Aesthetic Dental Procedures	Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth.
Bone Grafts	Bone grafts done in connection with extractions, apicoectomies or non-covered/ineligible implant.
Cone Beam Imaging/MRI Procedures	
Cosmetic/Reconstructive Services and Supplies	Cosmetic and/or reconstructive services and supplies, except for Dentally Appropriate services and supplies to treat a Congenital Anomaly and to restore a physical bodily function lost as a result of Injury or Illness.
Decay Prevention	Supplies and materials to prevent decay, such as toothpaste, fluoride gels, dental floss, and teeth whiteners.
Duplicate Services	Services submitted by a Dentist which are for the same services performed on the same date for the same Member by another Dentist.
Experimental or Investigational Services	
Fabrication of Athletic Mouth Guard	
Facility Expenses	Services and supplies related to facility expenses, including, but not limited to: those performed by a Dentist who is compensated by a facility for similar Covered Services performed for Member; and costs or any additional fees that the Dentist or Hospital charges for treatment at the Hospital (inpatient or outpatient).
Failure to Comply	Services and supplies resulting from Your failure to comply with professionally prescribed treatment.
Gold-Foil Restorations	
Oral Sedation	
Nitrous Oxide	
Oral Hygiene and Dietary Instructions	
Orthodontic Dental Services	Except when Dentally Appropriate, We will not cover services and supplies provided in connection with orthodontics, including the following: correction of

	malocclusion; craniomandibular orthopedic treatment; other orthodontic treatment; preventive orthodontic procedures; procedures for tooth movement, regardless of purpose; and repair of damaged orthodontic appliances.

Plaque Control Programs	
Precision Attachments, Precious Metal Bases and Other Specialized Techniques	
Provisional, Temporary and Duplicate Devices or Appliances	
Replacements	Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.
Sealants	Except as provided for permanent molars.
Separate Charges	Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following: any supplies; local anesthesia; and sterilization (office infection control charges).
Services and Supplies to Alter Vertical Dimension and/or Restore or Maintain the Occlusion	Services and supplies to alter vertical dimension and/or restore or maintain the occlusion, including the following: equilibration; periodontal splinting; full mouth rehabilitation; and restoration for misalignment of teeth.
Services and Supplies Which the Insured Would Have No Legal Obligation to Pay in the Absence of this Coverage	
Services Provided by Certain Entities	Services and treatment received from a Dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration Hospital or similar person or group.
Specialized Procedures and Techniques	
Temporomandibular Joint (TMJ) Disorder Treatment	Services and supplies provided in connection with temporomandibular joint (TMJ) disorder.
Topical Medicament Center	

This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. For full coverage provisions, refer to the contract.