Regence Individual Direct Plan Highlights
Gold 750, Silver 3000, Bronze Essential 6850, Oregon Standard Silver, Oregon Standard Bronze
1/1/2016

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 from an approved In-Network telehealth provider.
- In-Network office visits are not subject to the deductible on the Gold 750, Silver 3000 and Oregon Standard Silver Plans.
- 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. Out-of-Network services are covered 50% on all plans after Out-of-Network deductible is met and until out-of-pocket maximum is met, except where noted.

Calendar Year Deductible

In-Network	Gold 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
Individual/Family	$750/$1,500	$3,000/$6,000	$6,850/$13,700	$2,500/$5,000	$5,000/$10,000
Out-of-Network	**Gold 750**	**Silver 3000**	**Bronze Essential 6850**	**Oregon Standard Silver**	**Oregon Standard Bronze**
Individual/Family	$5,000/$10,000	$12,000/$24,000	$13,700/$27,400	$10,000/$20,000	$10,000/$20,000

Calendar Year Out-of-Pocket Maximum

In-Network	Gold 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
Individual/Family	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700	$6,350/$12,700	$6,350/$12,700
Out-of-Network	**Gold 750**	**Silver 3000**	**Bronze Essential 6850**	**Oregon Standard Silver**	**Oregon Standard Bronze**
Individual/Family	$20,550/$41,100	$20,550/$41,100	$20,550/$41,100	$12,700/$25,400	$12,700/$25,400

10 Essential Health Benefits - Covered Services

1. Ambulatory Patient Services (Outpatient Care)	In-Network Member Responsibility				
	Gold 750	**Silver 3000**	**Bronze Essential 6850**	**Oregon Standard Silver**	**Oregon Standard Bronze**
Office Visits	Not subject to deductible Primary care: $40 copay Specialist Care: $60 copay Urgent Care: $60 copay	Not subject to deductible Primary care: $40 copay Specialist Care: $60 copay Urgent Care: $60 copay	Primary care: 2 upfront visits at $40 copay, then 0% after deductible Specialist Care: 0% after deductible Urgent Care: 0% after deductible	Not subject to deductible Primary Care: $35 copay Specialist Care: $70 copay Urgent Care: $90 copay	Primary Care: $60 copay Specialist Care: $100 copay Urgent Care: $120 copay
Ambulatory Surgical Center services and supplies	10%	20%	0%	30%	50%
Hospital outpatient services and supplies	20%	30%	0%	30%	50%
Complex Outpatient Imaging (CTs, MRIs, PETs)	20%	30%	0%	30%	50%

2. Emergency Services In-Network benefits apply regardless of provider network	**Gold 750**	**Silver 3000**	**Bronze Essential 6850**	**Oregon Standard Silver**	**Oregon Standard Bronze**
Emergency Room	20%	30%	0%	30%	50%
Ambulance	20%	30%	0%	30%	50%

3. Hospitalization	**Gold 750**	**Silver 3000**	**Bronze Essential 6850**	**Oregon Standard Silver**	**Oregon Standard Bronze**
Inpatient services and supplies	20%	30%	0%	30%	50%

4. Maternity and Newborn Care	Gold 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
Pregnancy care, childbirth and complications of pregnancy, and Newborn Care	20%	30%	0%	30%	50%

5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment	Gold 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
Inpatient Services	20%	30%	0%	30%	50%
Outpatient Services	Not subject to deductible $40 copay	30%	0%	Not subject to deductible $35 copay	$60 copay

6. Prescription Medications[1]	Gold 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
Calendar Year Deductible In-Network medical deductible applies unless otherwise specified	Medical deductible waived for Tier 1 and Tier 2	Medical deductible waived for Tier 1 and Tier 2	Medical deductible waived for Tier 1	Medical deductible waived	Medical deductible applies
Tier 1: Generics (Category 1) Standard plans: Generics	$10 Retail / $20 Mail	$15 Retail / $30 Mail	$20 Retail / $40 Mail	$15 Retail / $30 Mail	$20 Retail / $40 Mail
Tier 2: Generics (Category 2) and Brand Name (Category 1) Standard plans: Preferred Brand	$40 Retail / $80 Mail	$50 Retail / $100 Mail	0% Retail / 0% Mail	$50 Retail / $100 Mail	$80 Retail / $160 Mail
Tier 3: Brand Name (Category 2) Standard plans: Non-Preferred Brand	50% Retail / 40% Mail	50% Retail / 40% Mail	0% Retail / 0% Mail	50% Retail / 40% Mail	50% Retail / 40% Mail
Tier 4: Specialty Medications	40%	40%	0%	50%	50%

[1] All out-of-pocket expenses go towards In-Network Medical Out-of-Pocket Maximum. Essential Formulary applies to all plans except the Oregon Standard Silver and Oregon Standard Bronze plans which use the Oregon Standard Formulary. 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 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
Rehabilitation Services (Inpatient) • 30 days per calendar year	20%	30%	0%	30%	50%
Rehabilitation Services (Outpatient) • 30 visits per calendar year	20%	30%	0%	Not subject to deductible $35 copay	$60 copay
Habilitative Services (Inpatient) • 30 days per calendar year	20%	30%	0%	30%	50%
Habilitative Services (Outpatient) • 30 visits per calendar year	20%	30%	0%	Not subject to deductible $35 copay	$60 copay
Durable Medical Equipment	20%	30%	0%	30%	50%

8. Laboratory Services	Gold 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
Outpatient Radiology and Laboratory and Diagnostic imaging including X-rays (Complex Outpatient Imaging refer to Ambulatory Patient Services)	Not subject to deductible 20%	30%	0%	30%	50%

9. Preventive Services	Gold 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
In-Network not subject to deductible	0%	0%	0%	0%	0%

10. Pediatric Services	Gold 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
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	Not covered	Not covered
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 • Oregon Standard Silver and Bronze plans: 0% for lenses specified in state law	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	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 750	Silver 3000	Bronze Essential 6850	Oregon Standard Silver	Oregon Standard Bronze
Complementary Care • $500 per calendar year for acupuncture and spinal manipulations combined	Not subject to deductible $20 copay	Not subject to deductible $20 copay	Not covered	Not covered	Not covered

Additional Information	All Plans
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. Value PPO provider network: Plan benefits apply as described within this document, and members may receive discounts on their services. All other provider networks: Out-of-Network plan benefits apply as described within this document.

Questions and Answers

How do I find out more about the providers available in my network?	**Gold 750, Silver 3000 and Bronze Essential 6850** • The networks available are MyChoice Northwest and Value PPO. **Oregon Standard Silver and Oregon Standard Bronze** • The networks available are MyChoice Northwest, Value PPO, Legacy Health and Willamette Valley Health Solution. • You can visit www.regence.com/find-a-doctor to search for providers in your network.
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:

Cosmetic/Reconstructive Services and Supplies	Except as necessary for reconstruction for functional injury and disease or as required by state/federal mandates such as reconstructive breast surgery following a mastectomy for cancer; to correct a congenital anomaly; to correct a craniofacial anomaly; to restore a physical bodily function lost as a result of Injury or Illness; for one attempt to correct a scar or defect that resulted from an accidental Injury or treatment for an accidental Injury, provided the attempt is made within 18 months of the accidental Injury or treatment causing the scar or defect (or, if delay is medically necessary, as soon thereafter as correction is appropriate); or for one attempt to correct a scar or defect on the head or neck that resulted from a surgery, provided the attempt is made within 18 months of the surgery causing the scar or defect (or, if delay is medically necessary, as soon thereafter as correction is appropriate).
Counseling in the absence of illness	Unless a covered benefit or required by law.
Custodial Care	Non-skilled care and helping with activities of daily living unless member is eligible for Palliative Care benefits.
Dental Examinations and Treatments	Except when covered under the Pediatric Dental benefit or the Injury to Teeth benefit.
Fees, Taxes, Interest	Charges for shipping and handling, postage, interest, or finance charges that a provider might bill.
Government Programs	Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program.
Infertility Treatment	Except to the extent covered services are required to diagnose such condition.
Investigational Services	Treatment or procedures (health interventions) and services, supplies, and accommodations provided in connection with investigational treatments or procedures.
Military Service Related Conditions	The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection or conditions incurred in or aggravated during performance in the Uniformed Services.
Motor Vehicle Coverage and Other Insurance Liability	
Non-Direct Patient Care	Includes appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person (except as specifically allowed under the telemedicine and telehealth medical benefits).
Non-Duplication of Medicare	Services and supplies to the extent payable under Medicare, when by law, the plan would not be primary to Medicare had the member properly enrolled in Medicare when first eligible regardless of whether or not the member actually enrolled.

Obesity or Weight Reduction/Control	Medical treatment, medication, surgical treatment (including reversals), programs, or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis.
Orthognathic Surgery	Except for injury, sleep apnea or congenital anomaly (including craniofacial anomalies).
Personal Comfort Items	Items that are primarily for comfort, convenience, cosmetics, environmental control, or education.
Physical Exercise Programs and Equipment	Includes hot tubs or membership fees at spas, health clubs, or other such facilities; applies even if the program, equipment, or membership is recommended by the member's provider.
Private Duty Nursing	Includes ongoing shift care in the home.
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 while committing an illegal act or felony.
Routine Foot Care	
Routine Hearing Exams	
Self-Help, Self-Care, Training, or Instructional Programs	Includes, but is not limited to control weight, or provide general fitness (childbirth classes); Programs that teach a person how to use durable medical equipment or how to care for a family member.
Services and Supplies Provided by a Member of Your Family	
Services and Supplies That Are Not Medically Necessary	
Services to Alter Refractive Character of the Eye	
Sexual Dysfunction	Services and supplies for or in connection with sexual dysfunction, except for Medically Necessary mental health services and supplies for a diagnosis of sexual dysfunction.
Sexual Reassignment Surgery	Surgical services for sexual reassignment, except a surgical service that is medically necessary to treat a member's diagnosis of gender identity disorder or gender dysphoria is covered if that same surgical service is a covered service when it is medically necessary treatment of any other diagnosis in any member.
Temporomandibular Joint Disorders (TMJ)	

Third-Party Liability	Services and supplies for treatment of illness or injury for which a third party is responsible.
Travel and Transportation Expenses	Other than covered ambulance services and for transplant services for the patient and caregiver.
Work-Related Conditions	Except for subscribers and enrolled dependents who are owners, partners, or corporate officers and are exempt from L&I coverage.

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 750, Silver 3000, Silver HSA 2000, Bronze HSA 6550, Bronze Essential 6850
1/1/2016

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 750, Silver 3000, Silver HSA 2000, Bronze HSA 6550 and Bronze Essential 6850 plans. There is no coverage for the Oregon Standard Silver and Oregon Standard Bronze plans.

Calendar Year Deductible

Deductible waived on all services

Covered Services (per member)

Preventive and Diagnostic Services	Member Responsibility In-Network/Out-of-Network
X-rays: • Routine radiology: 1 (set) per calendar year • Bitewing x-ray series: 1 (set) per calendar year • Panoramic or intra-oral complete series: Once every 5 calendar years **Cleanings:** 2 per calendar year **Routine and diagnostic oral examinations:** 2 per calendar year **Topical fluoride application:** 2 treatments per calendar year **Sealants (permanent molars):** Once per molar during a 5-year period under 16 years of age **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:** 2 per calendar year (in lieu of preventive cleanings) **Periodontal debridement:** Once in a 2-year period **Scaling and Root Planing:** Once in a 2-year period **Endodontic services** including root canal treatment, pulpotomy and apicoectomy	**20%**

Major Services

Crowns, inlays and onlays: • Crowns limited to age 16 up to age 19 • Permanent crowns limited to 4 (including replacement crowns) in a 7-year period • Permanent crown replacement limited to once within a 7-year period after placement **Dentures (full or partial):** limited to age 16 up to age 19 **Bridges (fixed partial denture)** **Orthodontia:** Covered when medically necessary	**50%**

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.