Regence Individual Direct Benefit Highlights

Gold, Silver, Bronze HSA

1/1/14

Plan Features

- Provider choice: For In-Network benefits, members have direct access to their choice of providers within the Preferred network. Member coinsurance levels are 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.
- In-Network Primary Care office visits are not subject to the deductible on Silver & Gold Plans.l

	Gold	Silver	Bronze HSA
Calendar Year Deductible			
• Separate deductible amounts per calendar year for In-Network / Out- of-Network providers. • Applies to all covered expenses except where noted	Individual **$1,000/$5,000** Family **$2,000/None**	Individual **$3,000/$10,000** Family **$6,000/None**	Single **$5,000/$10,000** Family **$10,000/$10,000**
Calendar Year Out-of-Pocket Maximums			
• Separate out-of-pocket maximum amounts for In-Network / Out-of-Network providers • 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	Individual **$3,300/$12,500** Family **$6,600/None**	Individual **$4,900/$12,500** Family **$9,800/None**	Single **$6,250/$12,500** Family **$12,500/$12,500**

Covered Services

- 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% after Out-of-Network deductible is met and until out-of-pocket maximum is met, except where noted.

	Gold	Silver	Bronze HSA
Office Visits In-Network Primary Care office visits are not subject to the deductible on Silver & Gold Plans	**20%**	**20%**	**30%**
Outpatient Radiology and Laboratory	**20%**	**20%**	**30%**
Chemical Dependency/Mental Health	**20%**	**20%**	**30%**
Preventive Care and Immunizations (In-Network not subject to deductible)	**0%**	**0%**	**0%**
Hospital Services Inpatient and outpatient services and supplies	**20%**	**20%**	**30%**
Home Health 130 visits per calendar year	**20%**	**20%**	**30%**
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime	**20%**	**20%**	**30%**
Maternity	**20%**	**20%**	**30%**
Neurodevelopmental Inpatient: no limit Outpatient: 25 visits per calendar year	**20%**	**20%**	**30%**
Rehabilitation Services Inpatient: 30 days per calendar year Outpatient: 25 visits per calendar year	**20%**	**20%**	**30%**
Skilled Nursing Facility 60 days per calendar year	**20%**	**20%**	**30%**

Spinal Manipulations 10 spinal manipulations per calendar year	**20%**	**20%**	**30%**
Emergency Room Services In-Network deductible, coinsurance and In-Network out-of-pocket maximum apply regardless of provider network.	**$200 Copay (waived if admitted)** **20%**	**$200 Copay (waived if admitted)** **20%**	**30%**

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Prescription Medications	Gold	Silver	Bronze HSA
Deductible (per calendar year) In-Network medical deductible applies unless otherwise specified	**Deductible waived for Tier 1**	**Deductible waived for Tier 1**	**Deductible applies**
Tier 1: Generics	**$10 Retail/$20 Mail**	**$10 Retail/$20 Mail**	**25% Retail/20% Mail**
Tier 2: Brand Name (Category 1)	**30% Retail/25% Mail**	**30% Retail/25% Mail**	**35% Retail/20% Mail**
Tier 3: Brand Name (Category 2)	**50% Retail/40% Mail**	**50% Retail/40% Mail**	**50% Retail/40% Mail**
Tier 4: Specialty Medications	**40% Retail/40% Mail**	**40% Retail/40% Mail**	**40% Retail/40% Mail**
Out-of-Pocket Maximum	• All out-of-pocket expenses go towards In-Network Medical Out-of-Pocket Maximum.		
Drug List	Essential Formulary		
Other	• Specialty medications covered at participating retail pharmacies for first fill only. After first fill members use specialty pharmacies. • Specialty Medications and Self Administrable: Up to 30-day supply per fill. • Nonparticipating pharmacies not covered.		

Pediatric Dental Services

• Various limits apply. Covered for members up to age 19 • **Bronze HSA:** In-Network deductible applies to all dental services • **All other Plans:** Deductible waived on all dental services	Member responsibility for both In-Network/Out-of-Network: **Preventive: 0%** **Restorative: 20%** **Major: 50%** Applies to In-Network out-of-pocket maximum

Pediatric Vision Services

• Covered for members up to age 19 • One routine eye exam per calendar year. • One pair (two lenses) and one standard frame per calendar year. • Contacts covered in lieu of glasses	Member responsibility for both In-Network/Out-of-Network: **Eye Exam: 0%** **Vision Hardware: 0%** Deductible waived on all services Applies to In-Network out-of-pocket maximum,

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Optional Benefits Available	Gold	Silver	Bronze HSA
PACKAGE OPTION: **Adult Dental, Adult Vision and IAP** Covered for members age 19 and older **Bronze HSA:** In-Network deductible applies to all dental and vision services **All other Plans: In-Network deductible does not apply**	**Adult Dental** • No deductible and 0% for Preventive care $50 deductible per calendar year for Basic and Major Care (Does not apply to Bronze HSA) • 20% for Basic care • 50% for Major care • Adult dental waiting periods for enrollees with no prior coverage: 6 months for Basic Services and 12 months for Major Services. $750 per calendar year maximum **Adult Vision** • No deductible • One routine exam per calendar year, no member responsibility • Lenses and frames: $150 limit per calendar year **Individual Assistance Program (IAP)** • Eight sessions, no member responsibility • Reliant Behavioral Health Network		

Additional Information

Waiting Periods	• No benefits are provided for treatment relating to a transplant until the member has been covered under this or a prior plan for 90 days. Members may receive credit from prior medical coverage.
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 above, and members may receive discounts on their services.

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:** All cosmetic/reconstructive services and supplies are excluded except for reconstruction for functional injury and disease or as required by state/federal mandates such as reconstructive breast surgery following a mastectomy for cancer.
- **Counseling:** Counseling in the absence of illness, unless covered under separate option
- **Custodial Care:** Non-skilled care and helping with activities of daily living
- **Dental Examinations and Treatments:** Services and supplies for dental services are excluded except when covered under the Pediatric dental benefit or any dental option
- **Fees, Taxes, Interest:** Charges for shipping and handling, postage, interest, or finance charges that a provider might bill; except sales taxes for durable medical equipment and mobility enhancing equipment.
- **Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program
- **Infertility:** 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
- **Medications without a Prescription Order**
- **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:** including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges
- **Obesity or Weight Reduction/Control:** Medical treatment, 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 congenital conditions, temporomandibular joint disorder, injury, and sleep apnea
- **Personal Comfort Items:** Items that are primarily for comfort, convenience, cosmetics, environmental control, or education
- **Physical Exercise Programs and Equipment: i**ncluding 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:** including ongoing shift care in the home
- **Riot, Rebellion and Illegal Acts: S**ervices 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 Eye Exam and Hardware:** Routine eye exam and hardware is excluded except where covered

under the Pediatric Vision benefit or as an optional benefit

- **Routine Foot Care** including treatment of corns and calluses and trimming of nails
- **Routine hearing exam, hearing aids, and other hearing devices:** routine hearing exam, hearing aids (externally worn or surgically implanted), and other hearing devices.
- **Self-Help, Self-Care, Training, or Instructional Programs** Self-help or training programs, including, but 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:** Regardless of cause, except for counseling provided by covered, licensed mental health practitioners
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, and counseling services for sexual reassignment
- **Third-Party Liability:** Services and supplies for treatment of illness or injury for which a third party is responsible
- **Work-Related Conditions:** except for subscribers and spouses only who are both 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.