Regence EmployeeChoice HSA Plan Highlights
Gold HSA 1400, Silver HSA 2000, Silver HSA 4000, Bronze HSA 3500, Bronze HSA 5000
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. A member may pay less out-of-pocket if a surgical procedure is performed at an In-Network 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.
- Members get access to Optimum Value Medication List generics and certain medications for chronic conditions, before satisfying a deductible on all plans.
- 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 HSA 1400	Silver HSA 2000	Silver HSA 4000	Bronze HSA 3500	Bronze HSA 5000
Single/Family	$1,400/$2,800	$2,000/$4,000	$4,000/$8,000	$3,500/$7,000	$5,000/$10,000
Out-of-Network	**Gold HSA 1400**	**Silver HSA 2000**	**Silver HSA 4000**	**Bronze HSA 3500**	**Bronze HSA 5000**
Single/Family	$4,000/$8,000	$4,000/$8,000	$4,000/$8,000	$6,000/$12,000	$6,000/$12,000

Calendar Year Out-of-Pocket Maximum[1]

In-Network	Gold HSA 1400	Silver HSA 2000	Silver HSA 4000	Bronze HSA 3500	Bronze HSA 5000
Single/Family	$3,000/$6,000	$5,000/$10,000	$4,000/$8,000	$6,550/$13,100	$6,550/$13,100
Out-of-Network	**Gold HSA 1400**	**Silver HSA 2000**	**Silver HSA 4000**	**Bronze HSA 3500**	**Bronze HSA 5000**
Single/Family	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000	$12,500/$25,000	$12,500/$25,000

[1] 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. An individual family member will not exceed $6,850 for in-network out-of-pocket expenses within the calendar year.

10 Essential Health Benefits - Covered Services

	In-Network Member Responsibility				
1. Ambulatory Patient Services (Outpatient Care)	**Gold HSA 1400**	**Silver HSA 2000**	**Silver HSA 4000**	**Bronze HSA 3500**	**Bronze HSA 5000**
Office Visits	20%	30%	0%	50%	50%
Ambulatory Surgical Center services and supplies	10%	20%	0%	40%	40%
Hospital outpatient services and supplies	20%	30%	0%	50%	50%
Acupuncture • 12 visits per calendar year	20%	30%	0%	50%	50%
Spinal Manipulations • 15 spinal manipulations per calendar year	20%	30%	0%	50%	50%

2. Emergency Services In-Network benefits apply regardless of provider network	**Gold HSA 1400**	**Silver HSA 2000**	**Silver HSA 4000**	**Bronze HSA 3500**	**Bronze HSA 5000**
Emergency Room	20%	30%	0%	50%	50%
Ambulance	20%	30%	0%	50%	50%

3. Hospitalization	**Gold HSA 1400**	**Silver HSA 2000**	**Silver HSA 4000**	**Bronze HSA 3500**	**Bronze HSA 5000**
Inpatient services and supplies	20%	30%	0%	50%	50%

4. Maternity and Newborn Care	Gold HSA 1400	Silver HSA 2000	Silver HSA 4000	Bronze HSA 3500	Bronze HSA 5000
Pregnancy care, childbirth and complications of pregnancy, and Newborn Care	20%	30%	0%	50%	50%

5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment	Gold HSA 1400	Silver HSA 2000	Silver HSA 4000	Bronze HSA 3500	Bronze HSA 5000
Inpatient Services	20%	30%	0%	50%	50%
Outpatient Services	20%	30%	0%	50%	50%

6. Prescription Medications[2]	Gold HSA 1400	Silver HSA 2000	Silver HSA 4000	Bronze HSA 3500	Bronze HSA 5000
Calendar Year Deductible In-Network medical deductible applies unless otherwise specified	Medical deductible applies	Medical deductible applies	Medical deductible applies	Medical deductible applies	Medical deductible applies
Tier 1: Generics	10% Retail / 5% Mail	25% Retail / 20% Mail	0% Retail / 0% Mail	50% Retail / 40% Mail	50% Retail / 40% Mail
Tier 2: Brand Name (Category 1)	20% Retail / 15% Mail	35% Retail / 30% Mail	0% Retail / 0% Mail	50% Retail / 40% Mail	50% Retail / 40% Mail
Tier 3: Brand Name (Category 2)	50% Retail / 40% Mail	50% Retail / 40% Mail	0% Retail / 0% Mail	50% Retail / 40% Mail	50% Retail / 40% Mail
Tier 4: Specialty Medications	50%	50%	0%	50%	50%

[2] 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% 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 HSA 1400	Silver HSA 2000	Silver HSA 4000	Bronze HSA 3500	Bronze HSA 5000
Rehabilitation Services (Inpatient) • 30 days per calendar year	20%	30%	0%	50%	50%
Rehabilitation Services (Outpatient) • 25 visits per calendar year	20%	30%	0%	50%	50%
Habilitative Services (Inpatient) • 30 days per calendar year	20%	30%	0%	50%	50%
Habilitative Services (Outpatient) • 25 visits per calendar year	20%	30%	0%	50%	50%
Durable Medical Equipment	20%	30%	0%	50%	50%

8. Laboratory Services	Gold HSA 1400	Silver HSA 2000	Silver HSA 4000	Bronze HSA 3500	Bronze HSA 5000
Outpatient Radiology and Laboratory and Diagnostic imaging including X-rays	20%	30%	0%	50%	50%
Complex Outpatient Imaging (CTs, MRIs, PETs)	20%	30%	0%	50%	50%

9. Preventive Services	Gold HSA 1400	Silver HSA 2000	Silver HSA 4000	Bronze HSA 3500	Bronze HSA 5000
In-Network not subject to deductible	0%	0%	0%	0%	0%

10. Pediatric Services	Gold HSA 1400	Silver HSA 2000	Silver HSA 4000	Bronze HSA 3500	Bronze HSA 5000
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 applies on all services Applies to In-Network out-of-pocket maximum	Preventive: 0% / Basic: 20% / Major: 50% Deductible applies on all services Applies to In-Network out-of-pocket maximum	Preventive/Basic/Major: 0% Deductible applies on all services Applies to In-Network out-of-pocket maximum	Preventive: 0% / Basic: 20% / Major: 50% Deductible applies on all services Applies to In-Network out-of-pocket maximum	Preventive: 0% / Basic: 20% / Major: 50% Deductible applies 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 frame per calendar year • Contacts in lieu of glasses	Eye exam: 0% / Vision Hardware: 0% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Eye exam: 0% / Vision Hardware: 0% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Eye exam: 0% / Vision Hardware: 0% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Eye exam: 0% / Vision Hardware: 0% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Eye exam: 0% / Vision Hardware: 0% Deductible waived on all services Applies to In-Network out-of-pocket maximum

Other Covered Services	All Plans
Employee Assistance Program (EAP)	No member responsibility for: Up to four face-to-face sessions per incident to manage stress or work-life balance situations Legal and financial assistance 24/7 crisis line

Optional Benefits Available	All Plans
Adult Vision	Covered for members age 19 and older. No member responsibility for: One routine eye exam per calendar year. Hardware limited to $150 per calendar year. Not subject to deductible.

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. 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?	• The available networks are Preferred, EvergreenHealth Partners/Virginia Mason, The Everett Clinic, MultiCare and UW Medicine. • 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)?	**EvergreenHealth Partners/Virginia Mason, The Everett Clinic, MultiCare and UW Medicine** • Yes, you must select a primary care provider (PCP). Your PCP will coordinate your care and is responsible for meeting quality guideline. • Your PCP must be a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physican's Assistant (PA), Nurse Practitioner (NP), or Advanced Registered Nurse Practitioner (ARNP) in Family Medicine, General Practice, General Internal Medicine, OB/Gyn, obstetrics, geriatrics, preventive, adult medicine, or women's health. **Preferred** • 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 for reconstruction for functional injury and disease, to treat a congenital anomaly, and for breast reconstruction following a medically necessary mastectomy to the extent required by law.
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.
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 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).
Obesity or Weight Reduction/Control	Medical treatment, medications, 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 anomaly, 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	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, 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	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	Regardless of cause, except for counseling provided by covered, licensed practitioners.
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 their 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.