Regence Individual Direct Plan Highlights

Platinum High, Gold+ High, Gold, Silver+, Silver
1/1/2015

Plan Features

- Provider choice: 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. In-Network Specialist visits are not subject to the deductible on the Platinum High, Gold+ High and Silver+ Plans.

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

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Covered Services	MEMBER RESPONSIBILITY*				
	Platinum High	**Gold+ High**	**Gold**	**Silver+**	**Silver**
Preventive Care and Immunizations In-Network not subject to deductible	0%	0%	0%	0%	0%
Office Visits In-Network Primary care office visits	$20 copay, not subject to deductible	$30 copay, not subject to deductible	20%, not subject to deductible	$30 copay, not subject to deductible	20%, not subject to deductible
In-Network Specialist office visits	$30 copay, not subject to deductible	$45 copay, not subject to deductible	20%	$50 copay, not subject to deductible	20%
Outpatient Radiology and Laboratory Platinum High and Gold+ High Plans: In-Network outpatient radiology and laboratory services are not subject to the deductible.	10%	20%	20%	30%	20%
Acupuncture 12 visits per calendar year	10%	20%	20%	30%	20%
Chemical Dependency/Mental Health (Outpatient)	$20 copay	$30 copay	20%	30%	20%
Chemical Dependency/Mental Health (Inpatient)	10%	20%	20%	30%	20%
Emergency Room Services In-Network deductible, coinsurance and In-Network out-of-pocket maximum apply regardless of provider network.	$150 Copay per visit (waived if admitted) 10%	$200 Copay per visit (waived if admitted) 20%	$200 Copay per visit (waived if admitted) 20%	$200 Copay per visit (waived if admitted) 30%	$200 Copay per visit (waived if admitted) 20%
Hospital Services Inpatient and outpatient services and supplies.	10%	20%	20%	30%	20%

* **Member responsibility for In-Network services is indicated above, 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.**

Home Health 130 visits per calendar year	10%	20%	20%	30%	20%
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime	10%	20%	20%	30%	20%
Maternity	10%	20%	20%	30%	20%
Rehabilitation Services Inpatient: 30 days per calendar year Outpatient: 25 visits per calendar year	10%	20%	20%	30%	20%
Neurodevelopmental Therapy Inpatient: no limit Outpatient: 25 visits per calendar year	10%	20%	20%	30%	20%
Skilled Nursing Facility 60 inpatient days per calendar year	10%	20%	20%	30%	20%
Spinal Manipulations 10 spinal manipulations per calendar year	10%	20%	20%	30%	20%

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1/1/2015

Prescription Medications

- All out-of-pocket expenses go towards In-Network Medical Out-of-Pocket Maximum.
- Essential Formulary applies to all plans.
- Retail: Up to 30-day supply.
- 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: Up to 30-day supply per fill.

	Platinum High	Gold+ High	Gold	Silver+	Silver
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 for Tier 1	Medial deductible waived for Tier 1
Tier 1: Generics	$5 Retail / $10 Mail	$5 Retail / $10 Mail	$10 Retail / $20 Mail	$15 Retail / $30 Mail	$10 Retail / $20 Mail
Tier 2: Brand Name (Category 1)	$20 Retail / $40 Mail	$30 Retail / $60 Mail	30% Retail / 25% Mail	40% Retail / 35% Mail	30% Retail / 25% Mail
Tier 3: Brand Name (Category 2)	50% Retail / 40% Mail	50% Retail / 40% Mail	50% Retail / 40% Mail	50% Retail / 40% Mail	50% Retail / 40% Mail
Tier 4: Specialty Medications	40%	40%	40%	40%	40%

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1/1/2015

Pediatric Dental Services	Platinum High	Gold+ High	Gold	Silver+	Silver
• Various limits apply. • Covered for members up to age 19 • Deductible waived on all 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	**Platinum High**	**Gold+ High**	**Gold**	**Silver+**	**Silver**
• Covered for members up to age 19 • One routine eye exam per calendar year. • One pair (two lenses) and one frame per calendar year. • Contacts in lieu of glasses.	Member responsibility for both In-Network / Out-of-Network Eye exam: 0% / Vision Hardware: 0% Deductible waived on all services.				
Optional Benefits Available	**Platinum High**	**Gold+ High**	**Gold**	**Silver+**	**Silver**
PACKAGE OPTION: **Adult Dental, Adult Vision and IAP** Adult Dental and Adult Vision covered for members age 19 and older 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 • 20% for Basic care • 50% for Major care • Adult dental waiting periods for enrollees with no prior Regence dental 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

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.

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 patient is eligible for Palliative Care benefits.
- **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 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** 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, 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 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** including 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:** 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 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**
- **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** 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.
- **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.

Regence Individual Direct Plan Highlights

Platinum High, Gold+ High, Gold, Silver+, Silver, Silver HSA, Bronze HSA, Bronze HSA+ – Pediatric Dental
1/1/15

Regence
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Pediatric Dental Services

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 Platinum High, Gold+ High, Gold, Silver+, Silver, Silver HSA, Bronze HSA and Bronze HSA+ plans.

Deductible	• **Silver HSA, Bronze HSA and Bronze HSA+:** In-Network deductible applies to all dental services • **All other Plans:** Deductible waived on all dental services

Covered services (per member)

Preventive and Diagnostic Services	**Member Responsibility** In-Network/Out-of-Network
X-rays: Bitewing x-rays: 2 sets per calendar year Complete intra-oral mouth x-rays: once in a 3-year period Occlusal intraoral x-rays: once in a 2-year period Panoramic mouth x-rays: once in a 3-year period	**0%**
Cleanings: 2 per calendar year	
Routine oral examinations: 2 per calendar year, beginning before 1 year of age	
Topical fluoride application: 3 treatments per calendar year	
Sealants (permanent bicuspids and molars)	
Space maintainers: age 12 years and under, subject to necessity	
Basic Services	
Fillings: Consisting of composite and amalgam restorations	**20%**
Oral Surgery: Uncomplicated and complex oral surgery procedures	
General dental anesthesia or intravenous sedation: Subject to necessity	
Emergency treatment for pain relief	
Periodontal Maintenance: once per quadrant in a calendar-year for age 13 years and older	
Periodontal debridement	
Scaling and Root Planing: once in a 2-year period per	

quadrant age 13 and older	
Endodontic services including root canal treatment, pulpotomy and apicoectomy	
Major Services	
Crowns, inlays and onlays: once within a 5-year period after placement, age 12 years and older	**50%**
Dentures (full or partial): Full: once 5 years after placement Partial: once within a 3-year period	
Bridges (fixed partial dentures): once within a 7-year period after placement	
Dental Implants: once per tooth within a 7-year period	
Orthodontia: Covered when medically necessary	

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