Regence Individual Direct Plan Highlights
Gold 1000, Silver 3000, Bronze Essential 7150, Bronze Essential 7150 EPO, Standard Silver, Standard Bronze
1/1/2017

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. The maximum allowed amount for services from a non-contracted facility is $3,000 per day. **All plans except Bronze Essential 7150 EPO**
- 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) 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. Out-of-Network services are covered 50% on Gold 1000, Silver 3000, Bronze Essential 7150, Standard Silver and Standard Bronze plans after Out-of-Network deductible is met and until out-of-pocket maximum is met, except where noted.
- Out-of-Network services are not covered on the Bronze Essential 7150 EPO plan.

Calendar Year Deductible

In-Network	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Individual/Family	$1,000/$2,000	$3,000/$6,000	$7,150/$14,300	$7,150/$14,300	$2,500/$5,000	$7,150/$14,300

Out-of-Network	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Individual/Family	$5,000/$10,000	$12,000/$24,000	$14,300/$28,600	Not covered	$10,000/$20,000	$14,300/$28,600

Calendar Year Out-of-Pocket Maximum

In-Network	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Individual/Family	$6,500/$13,000	$7,000/$14,000	$7,150/$14,300	$7,150/$14,300	$6,850/$13,700	$7,150/$14,300

Out-of-Network	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Individual/Family	None	None	None	Not covered	None	None

10 Essential Health Benefits - Covered Services

1. Ambulatory Patient Services (Outpatient Care)	In-Network Member Responsibility					
	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Office Visits	Not subject to deductible Primary care: $20 copay Specialist Care: $40 copay Urgent Care: $40 copay	Not subject to deductible Primary care: $30 copay Specialist Care: $50 copay Urgent Care: $50 copay	Primary, Specialist and Urgent Care: 2 upfront visits at $60 copay, then 0% after deductible	Primary, Specialist and Urgent Care: 2 upfront visits at $60 copay, then 0% after deductible	Not subject to deductible Primary Care: $35 copay Specialist Care: $70 copay Urgent Care: $70 copay	Not subject to deductible Primary Care: $70 copay Specialist Care: $115 copay Urgent Care: $100 copay
Ambulatory Surgical Center services and supplies	10%	20%	0%	0%	30%	0%
Hospital outpatient services and supplies	20%	30%	0%	0%	30%	0%
Complex Outpatient Imaging (CTs, MRIs, PETs)	20%	30%	0%	0%	30%	0%

2. Emergency Services In-Network benefits apply regardless of provider network	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Emergency Room	20%	30%	0%	0%	30%	0%
Ambulance	20%	30%	0%	0%	30%	0%

3. Hospitalization	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Inpatient services and supplies	20%	30%	0%	0%	30%	0%

4. Maternity and Newborn Care	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Pregnancy care, childbirth and complications of pregnancy, and Newborn Care	20%	30%	0%	0%	30%	0%

5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Inpatient Services	20%	30%	0%	0%	30%	0%
Outpatient Services • Outpatient therapy visit	20%	30%	0%	0%	Not subject to deductible $35 copay	Not subject to deductible $70 copay
• Other outpatient services such as testing and non-therapy services	20%	30%	0%	0%	30%	0%

6. Prescription Medications[1]	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	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 for Tier 1	Medical deductible waived	Medical deductible waived for Tier 1 and Tier 2
Tier 1: Preferred Generic	$8 Retail / $16 Mail	$10 Retail / $20 Mail	$20 Retail / $40 Mail	$20 Retail / $40 Mail	$15 Retail / $30 Mail	$35 Retail / $70 Mail
Tier 2: Non-Preferred Generic	25% Retail / 20% Mail	25% Retail / 20% Mail	0% Retail / 0% Mail	0% Retail / 0% Mail	25% Retail / 20% Mail	25% Retail / 20% Mail
Tier 3: Preferred Brand	25% Retail / 20% Mail	35% Retail / 30% Mail	0% Retail / 0% Mail	0% Retail / 0% Mail	$50 Retail / $100 Mail	0% Retail / 0% Mail
Tier 4: Non-Preferred Brand	50% Retail / 45% Mail	50% Retail / 45% Mail	0% Retail / 0% Mail	0% Retail / 0% Mail	50% Retail / 45% Mail	0% Retail / 0% Mail
Tier 5: Preferred Specialty	40%	40%	0%	0%	40%	0%
Tier 6: Non-Preferred Specialty	50%	50%	0%	0%	50%	0%

[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, 3 and 4.

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 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Rehabilitation Services (Inpatient) • 30 days per calendar year	20%	30%	0%	0%	30%	0%
Rehabilitation Services (Outpatient) • 30 visits per calendar year	20%	30%	0%	0%	Not subject to deductible $35 copay	0%
Habilitative Services (Inpatient) • 30 days per calendar year	20%	30%	0%	0%	30%	0%
Habilitative Services (Outpatient) • 30 visits per calendar year	20%	30%	0%	0%	Not subject to deductible $35 copay	0%
Durable Medical Equipment	20%	30%	0%	0%	30%	0%

8. Laboratory Services	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
Outpatient Radiology and Laboratory and Diagnostic imaging including X-rays (Complex Outpatient Imaging refer to Ambulatory Patient Services)	20%	30%	0%	0%	30%	0%

9. Preventive Services	Gold 1000	Silver 3000	Bronze Essential 7150	Bronze Essential 7150 EPO	Standard Silver	Standard Bronze
In-Network not subject to deductible	0%	0%	0%	0%	0%	0%

10. Pediatric Services	**Gold 1000**	**Silver 3000**	**Bronze Essential 7150**	**Bronze Essential 7150 EPO**	**Standard Silver**	**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	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	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 7150**	**Bronze Essential 7150 EPO**	**Standard Silver**	**Standard Bronze**
Complementary Care • $500 per calendar year for acupuncture and chiropractic spinal manipulations combined	Not subject to deductible $20 copay	Not subject to deductible $30 copay	Not covered	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. ValuePPO 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?	• The network available is ValuePPO. • 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 1-888-675-6570 for additional information. (TTY users should call 711). Hours are 6:00 a.m. to 6:00 p.m., Monday through Friday. • *Esta información se encuentra disponible gratis en otros idiomas. Comuníquese con nuestro Servicios para Miembros al 1-888-675-6570 para obtener información adicional. Los usuarios de TTY deben llamar al 711. Las horas de atención son de 6:00 a.m. a 6:00 p.m., de lunes a viernes.*
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; or for one attempt to correct a scar or defect on the head or neck that resulted from a surgery.
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, treatment of infertility, including, but not limited to surgery and fertility drugs and medications is excluded.
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 Part B had the member properly enrolled in Medicare Part B when first eligible regardless of whether or not the member actually enrolled.

Obesity or Weight Reduction/Control	Treatment, medications, surgical treatment (including revisions, reversals and treatment of complications), programs, or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis, unless required by law.
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 childbirth-related classes including infant care; instructional programs including those 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.
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.

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.