Regence BluePoint 30/45 Plan Highlights

For Groups of 51+
1/1/2015

Plan Features

- Provider choice: Members have direct access to their choice of providers. 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 Out-of-Network allowed amount.
- Office visits and professional services performed in a provider's office, such as injections or office surgery, are not subject to the deductible for In-Network providers. In addition, the first $400 of outpatient radiology and laboratory services per calendar year are not subject to deductible.

Calendar Year Deductible

• Applies to all covered expenses except where noted • Separate deductible for In-Network and Out-of-Network services.	Individual deductible options per calendar year: In-Network/Out-of-Network • **$500 / $1,000** • **$750 / $1,500** • **$1,000 / $2,000** • **$1,500 / $3,000** • **$2,000 / $4,000** • **$3,000 / $6,000** • **$4,000 / $8,000** • **$5,000 / $10,000** Family deductible is two times the Individual deductible amounts

Calendar Year Out-of-Pocket Maximums

• Out-of-pocket maximum amount per calendar year, including deductible, applies to all covered expenses. • 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 • Separate out-of-pocket maximums for In-Network and Out-of-Network services • Individual Out-of-Network out-of-pocket maximum is two times In-Network amount • Family out-of-pocket maximum is two times the Individual amounts	Individual In-Network out-of-pocket maximum per calendar year: $500 and $750 deductible plans: **$3,000, $3,500, $4,000 or $6,350** $1,000 deductible plan**: $3,500, $4,000, $4,500 or $6,350** $1,500 deductible plan: **$4,000, $4,500, $5,000 or $6,350** $2,000 deductible plan: **$4,500, $5,000, $5,500 or $6,350** $3,000 deductible plan: **$5,000, $5,500 or $6,350** $4,000 deductible plan: **$5,500 or $6,350** $5,000 deductible plan: **$6,350**

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Covered Services	MEMBER RESPONSIBILITY	
	In-Network	Out-of-Network*
Preventive Care and Immunizations In-Network not subject to deductible	0%	45%
Office Visits In-Network not subject to deductible	Primary Care Provider: $35 copay Specialist/ Urgent Care Facility: $55 copay	45%
Expanded Office Services In-Network deductible waived. Professional services performed in a provider's office such as office surgery, injections, and related supplies such as anesthesia (does not include rehabilitation, mental health and other benefits covered within this plan).	0%	45%
Professional Services/ Outpatient Radiology and Laboratory Office and inpatient services and supplies	30%	45%
Upfront Outpatient Radiology and Laboratory First $400 per calendar year (deductible waived)	0%	
Hospital Services/ Ambulatory Surgical Center Inpatient and outpatient services and supplies	30%	45%
Home Health 130 visits per calendar year	30%	45%
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime	30%	45%
Maternity	30%	45%
Rehabilitation Services Inpatient: 15 days per calendar year Outpatient: 40 visits per calendar year	30%	45%
Skilled Nursing Facility 60 inpatient days per calendar year	30%	45%
Spinal Manipulations 10 spinal manipulations per calendar year	30%	45%
Emergency Room Services $150 copay per ER visit (waived if directly admitted)	30% (In-Network deductible and In-Network out-of-pocket maximum applies)	

*** Member may be responsible for any provider costs above the Out-of-Network allowed amount**

Prescription Medication Coverage

- Generics: not subject to deductible
- Deductible, copays and coinsurance apply to the In-Network medical out-of-pocket maximum
- Member may be balance billed when a nonparticipating pharmacy is used
- If an equivalent generic medication is available and a brand-name medication is chosen, the member is responsible for paying the applicable brand-name copay / coinsurance plus the difference in price between the equivalent generic medication and the brand-name medication not to exceed total retail cost.
- 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.
- Members must use a Specialty Pharmacy to obtain self-administered cancer chemotherapy drugs. Prescription medication deductible waived.
- On all plans, cancer chemotherapy drugs are paid the same as any other medication. On the $10/35%/50% plan only, the member has a maximum $300 copay per filled prescription.

Prescription medication deductible options per calendar year:

- $0, $100, $250

	Generic / Brand Formulary / Brand Non-Formulary		
	Option 1	**Option 2**	**Option 3**
Retail Up to 30 day supply	$5 / $25 / $50	$5 / $35 / $70	$10 / 35% / 50%
Mail Order Up to 90 day supply	$12.50 / $62.50 / $150	$12.50 / $87.50 / $210	$25 / 30% / 50%

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Optional Benefits Available With All Plans	MEMBER RESPONSIBILITY	
	In-Network	**Out-of-Network***
Chemical Dependency Treatment/Mental Health	Inpatient: 30% Outpatient: $35 copay (In-Network deductible waived)	Inpatient and Outpatient 45%
Spinal Manipulations Option with no benefit maximum	30%	45%
Emergency Room Services $150 copay per ER visit, option to waive deductible.	30% (In-Network out-of-pocket maximum applies)	
Upfront Outpatient Radiology & Laboratory Option of first $600 per calendar year (deductible waived).	0%	
Vision One routine eye exam per calendar year. Hardware limited to $150 per calendar year. Not subject to deductible.	0%	

Optional Program Available With All Plans

Employee Assistance Program (EAP)	No cost to the member 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

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 12 consecutive months. 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.

*** Member may be responsible for any provider costs above the Out-of-Network allowed amount**

General Medical Exclusions

Coverage is not provided for any of the following, including direct complications or consequences that arise from:

- **Acupuncture**
- **Cosmetic/Reconstructive Services and Supplies** except for reconstruction for functional injury and disease, to treat a congenital anomaly for members up to age 26, 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**
- **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
- **Immunizations** if the Insured receives them only for purposes of travel, occupation, or residency in a foreign country
- **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
- **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 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, sustained by a member while committing an illegal act or felony
- **Routine Foot Care**
- **Routine Hearing Care:** Routine hearing examinations, programs, or treatment for hearing loss including hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them, except for cochlear implants

- **Self-Help, Self-Care, Training, or Instructional Programs** including childbirth classes, diet and weight monitoring services and instruction programs, including those 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, if chemical dependency/mental health benefit coverage is selected
- **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 or may be responsible
- **Travel and Transportation Expenses** other than covered ambulance services
- **Work-Related Conditions** except for subscribers who are owners, partners, or corporate officers and are exempt from state or federal workers' compensation law

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.