Regence Engage 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 Category 1 providers. If a member chooses a Category 3 provider, the member may be required to pay costs above the Category 3 allowed amount.

Calendar Year Deductible

Applies to all covered expenses except where noted	Individual deductible options per calendar year: • **$0, $250, $500, $1,000, $2,000, $3,000, $5,000** Family deductible is three times the individual amount except: $5,000 deductible option is two times the individual amount

Calendar Year Out-of-Pocket Maximums

• Out-of-pocket maximum amount per calendar year, including deductible and copays, applies to all covered expenses, including prescription medications, 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 out-of-pocket maximum options per calendar year: • $0 and $250 deductible options: **$2,500, $3,500, $4,500, $6,350** • $500 deductible option: **$3,000, $4,000, $5,000, $6,350** • $1,000 deductible option: **$3,500, $4,500, $5,500, $6,350** • $2,000 deductible option: **$4,500, $5,500, $6,350** • $3,000 deductible option: **$5,500, $6,350** • $5,000 deductible option: **$6,350** Family out-of-pocket maximum is two times the individual amount

Covered Services	MEMBER RESPONSIBILITY*		
	Category 1: Preferred ValueCare or BlueOption	**Category 2: Participating**	**Category 3: Non-contracted**
Preventive Care and Immunizations Category 1 and 2: Not subject to deductible	0%	0%	25%
Professional Services/Radiology & Lab Office and inpatient services and supplies	20%	30%	30%
Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies	20%	30%	30%

* **Member may be responsible for any provider costs above the Category 3 allowed amount**

Maternity	20%	30%	30%
Rehabilitation Services Inpatient: 15 days per calendar year Outpatient: 40 visits per calendar year	20%	30%	30%
Home Health 130 visits per calendar year	20%	30%	30%
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime	20%	30%	30%
Skilled Nursing Facility 60 inpatient days per calendar year	20%	30%	30%
Spinal Manipulations 10 spinal manipulations per calendar year	20%	30%	30%
Emergency Room Services $100 copay per ER visit (waived if directly admitted)	20%	20%	20%

Prescription Medication Coverage

- Generics: not subject to deductible
- Retail: 30-day supply per copay
- Mail order: 90-day supply (one copay per 30-day supply)
- Up to 30-day supply for covered self-administrable injectable medications at retail and mail order.
- Deductible, copays and coinsurance apply to the 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 oral chemotherapy drugs. Prescription medication deductible does not apply to self-administered oral chemotherapy medications.

Prescription medication deductible options per calendar year:

- $0, $250, $500

Copay options:

- $10 generic / $35 brand-name formulary / $75 brand-name non-formulary
- $5 generic / $25 brand-name formulary / $50 brand-name non-formulary
- $7 generic / 25% brand-name formulary / 50% brand-name non-formulary
- $10 generic / 35% brand-name formulary / 50% brand-name non-formulary

- On the $7/25%/50% copay option and the $10/35%/50% copay option, oral chemotherapy medications are paid the same as any other medication up to a $300 maximum copay per filled prescription.

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Optional Benefits Available	Category 1: Preferred ValueCare or BlueOption	Category 2: Participating	Category 3: Non-contracted
Chemical Dependency Treatment/Mental Health No benefit maximum	20%	20%	30%
Spinal Manipulations Option with no benefit maximum	20%	30%	30%
Vision One routine eye exam per calendar year. Hardware limited to $150 per calendar year. Not subject to deductible.	0%	0%	0%

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.

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

- **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.