Regence HSA Healthplan 3.0 (Standard)
Plan Highlights

For Groups 51+
1/1/2015

Regence
your health, connected.℠

Plan Features

- The Regence HSA Healthplan 3.0 is a simple way to pay for life's medical expenses. Comprehensive health plan combined with a separate tax-free savings account provides a simple way to pay for life's medical expenses. You get broad medical coverage, support and guidance from an HSA specialist plus rewards for healthy living.
- Family coverage: no one family member is eligible for benefits until the entire family deductible is met. No one family member is eligible for 100% coverage until the entire family out-of-pocket maximum is met.

Calendar Year Deductible

• Separate deductible amounts per calendar year for In-Network / Out-of-Network providers. • Applies to all covered expenses except where noted.	In-Network / Out-of-Network deductible options • **$1,350 / $3,000** for single coverage **$2,700 / $6,000** for family coverage • **$1,500 / $3,000** for single coverage **$3,000 / $6,000** for family coverage • **$2,500 / $5,000** for single coverage **$5,000 / $10,000** for family coverage • **$3,500 / $5,000** for single coverage **$7,000 / $10,000** for family coverage

Calendar Year Out-of-Pocket Maximum

• Out-of-pocket maximum amount per calendar year, including deductible, applies to all covered expenses, except where noted. • Separate out-of-pocket amounts per calendar year for In-Network / Out-of-Network providers. • 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.	• **$3,600/$6,000** for single coverage on $1,350 deductible plan • **$3,000/$6,000** or **$5,000/$6,000** for single coverage on $1,500 deductible plan • **$5,000/$10,000** for single coverage on $2,500 and $3,500 deductible plans • **$7,200/$12,000** for family coverage on $2,500 deductible plan • **$6,000/$12,000** or **$10,000/$12,000** for family coverage on $3,000 deductible plan • **$10,000/$20,000** for family coverage on $5,000 and $7,000 deductible plans

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Covered Services	MEMBER RESPONSIBILITY	
	In-Network	Out-of-Network*
Professional Services Office and inpatient services and supplies	20%	40%
Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies	20%	40%
Maternity	20%	40%
Preventive Care and Immunizations In-Network: Not subject to deductible	0%	40%
Emergency Room Services	20%	20%
Rehabilitation Services Inpatient: 15 days per calendar year Outpatient: 40 visits per calendar year	20%	40%
Home Health 130 visits per calendar year	20%	40%
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime	20%	40%
Skilled Nursing Facility 60 inpatient days per calendar year	20%	40%
Spinal Manipulations 10 spinal manipulations per calendar year	20%	40%

Prescription Medication Coverage

• Subject to medical deductible. • Retail or Mail Order: Up to 90 day supply for covered prescription medications (Up to 30 day supply for covered self-administrable injectable medications). • Member may be balance billed when a nonparticipating pharmacy is used.	20%	20%

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

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Optional Benefits Available	In-Network	Out-of-Network*
Chemical Dependency Treatment/Mental Health No benefit maximums	20%	40%
Prescription Medication Coverage (in addition to standard prescription medication benefits) Select Generic, Brand Formulary and Brand Non-Formulary preventive medications for specific conditions on the Optimum Value Medication List are covered prior to deductible being met.	20%	20%
Spinal Manipulations No benefit maximum	20%	40%
Vision Not subject to deductible. One routine eye exam per calendar year. Hardware limited to $150 per calendar year maximum benefit.	0%	0%

Optional Program Available

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 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:

- **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

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

- **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 or 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.