

## Regence Activate<sup>SM</sup> Benefit Summary

for Clark County, WA



Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

In addition to the comprehensive benefits described below, Regence Activate provides a Member Choice Account you can fund with healthy behaviors. You can use these funds to pay your deductible and coinsurance. You can use these funds to pay your deductible and coinsurance. Please login to [www.myregence.com](http://www.myregence.com) today for more details and to get started.

<b>Annual Maximum</b>	<b>\$2,000,000 Annual Maximum</b>		
<b>Calendar Year Deductible</b> Applies to all covered expenses except where noted	Individual deductible options per calendar year: <b>\$1,500, \$2,000, \$3,000</b>  Family deductible is three times the individual amount		
<b>Calendar Year Coinsurance Maximum</b> Applies to all covered expenses except where noted When the coinsurance maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year	Individual coinsurance maximum options per calendar year: <b>\$3,000, \$4,000, \$6,000</b>  Family coinsurance maximum is three times the individual amount		
<b>Covered Services</b>	<b>Category 1 (Preferred)</b>	<b>Category 2 (Participating)</b>	<b>Category 3 (Non-contracted)</b> <small>(Member may be responsible for any provider costs above the Category 3 allowed amount)</small>
<b>Professional Services</b> Office and inpatient services and supplies	Benefits for services below will be provided at the percentage of the allowed amount specified, <u>after</u> deductible is met and until coinsurance maximum is met.		
<b>Hospital Services/Ambulatory Surgical Center</b> Inpatient and outpatient services and supplies <b>Maternity</b> (Subscriber and spouse)	80%	60%	60%
<b>Emergency Room Services</b> \$100 copay per ER visit (waived if directly admitted)		80%	80%

Covered Services	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)
Benefits for services below will be provided at the percentage of the allowed amount specified, <u>after</u> deductible is met and until coinsurance maximum is met.			
<b>Rehabilitation Services</b> Inpatient: 30 days per calendar year maximum benefit Outpatient: 25 visits per calendar year maximum benefit <hr/> <b>Acupuncture</b> 12 visits per calendar year <b>Spinal Manipulations</b> 10 spinal manipulations per calendar year	80%	60%	60%
<b>Preventive Care and Immunizations</b> Category 1 and 2: Not subject to deductible	100%	100%	60%
Covered Services	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)
Benefits for services below will be provided at the percentage of the allowed amount specified, <u>after</u> deductible is met and until coinsurance maximum is met.			
<b>Home Health</b> 130 visits per calendar year <b>Hospice</b> Respite care limited to 14 days inpatient/outpatient per lifetime <hr/> <b>Skilled Nursing Facility</b> 60 inpatient days per calendar year	80%	60%	60%

**Prescription Medication Coverage**

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-administerable injectible medications at retail and mail order.

**Prescription Medication Options**

Tiered plan design with four copay options and three deductible options

Prescription medication deductible options per calendar year: \$250, \$500, \$1,000

*Note: First dollar coverage for generics and formulary brands commonly used in the following five medication classes: asthma, diabetes, high blood pressure, high cholesterol and smoking cessation  
(not subject to deductible)*

*Diabetic patients can receive any generic medication for high cholesterol at \$0 copay.*

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/30% brand-name formulary/50% brand-name non-formulary**  
**10% generic/30% brand-name formulary/50% brand-name non-formulary**

Member may be balance billed when a nonparticipating pharmacy is used.

We cover certain preventive medications according to United States Preventive Services Task Force (USPSTF) guidelines at 100%, no deductible, no copay at participating pharmacies only. Member must have a prescription.

Covered Services	Optional Benefits Available (Optional benefits that are not elected are excluded from coverage)		
	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-contracted)
<b>Spinal Manipulations</b> Option with no benefit maximum	80%	60%	60%
<b>Vision</b> One routine eye exam per calendar year Hardware limited to \$150 per calendar year maximum benefit Not subject to deductible		100%	

Optional Program Available
<p>Employee Assistance Program (EAP)</p> <p>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</p>

Additional Information	
<b>Preventive Care</b>	Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA).
<b>Waiting Periods</b>	No benefits are provided for treatment relating to a transplant until the member has been covered under this or a prior plan for six consecutive months. There is a waiting period that must be met prior to benefits being available for pre-existing conditions: groups with 1-50 eligible employees have a nine-month pre-existing condition waiting period and groups with 51 or more eligible employees have a three-month pre-existing condition waiting period. Members may receive credit from prior medical coverage. Pre-existing condition waiting periods do not apply to Members up to age 19.
<b>Outside the Service Area</b>	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:

- **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
- **Custodial Care:** Non-skilled care and helping with activities of daily living
- **Dental Examinations and Treatments**
- **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** 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
- **Medications without a Prescription Order**
- **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

**General Medical Exclusions**

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

- **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
- **Riots, 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** including treatment of corns and calluses and trimming of nails
- **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 to learn how to stop smoking and 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 Reassignment Treatment and Surgery:** Treatment, surgery, and counseling services for sexual reassignment
- **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 or may be responsible
- **Tobacco Addiction Treatment**
- **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.