Regence HSA Healthplan 2.0 Benefit Highlights

* The Regence HSA Healthplan 2.0 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.

Annual Maximum	**$2,000,000 Annual Maximum**
Calendar Year Deductible Applies to all covered expenses except where noted	Deductible: **$3,000** for single coverage, **$5,000** or **$7,000** for family coverage. Benefits begin for one family member when the single deductible is met. When the family deductible is met, benefits begin for the entire family.
Calendar Year Out-of-Pocket Maximum 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.	Single coverage out-of-pocket maximum: **$5,000** Family coverage out-of-pocket maximum: **$10,000** Family coverage: no one family member is eligible for 100% coverage until the entire family out-of-pocket maximum is met.

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, after deductible is met and until out of pocket maximum is met.		
Professional Services Office and inpatient services and supplies	**80%**	**60%**	**60%**
Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies	**80%**	**60%**	**60%**
Maternity	**80%**	**60%**	**60%**
Preventive Care and Immunizations Not subject to deductible	**100%**	**100%**	**60%**
Emergency Room Services	**80%**	**80%**	**80%**
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)	**80%** 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. Specific Generic and Formulary Brand medications for the following chronic conditions are covered prior to deductible being met: asthma, diabetes, high blood pressure, high cholesterol, tobacco cessation.		

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, after deductible is met and until out of pocket maximum is met.		
Rehabilitation Services Inpatient: 30 days per calendar year Outpatient: 25 visits per calendar year	**80%**	**60%**	**60%**
Home Health 130 visits per calendar year	**80%**	**60%**	**60%**
Hospice Respite care limited to 14 days inpatient/outpatient per lifetime	**80%**	**60%**	**60%**
Skilled Nursing Facility 60 inpatient days per calendar year	**80%**	**60%**	**60%**
Chemical Dependency Treatment/Mental Health (Groups of 2-50): 45-day limit per calendar year for mental health residential treatment programs (Groups of 51+): No benefit limits for mental health residential treatment programs	**80%**	**60%**	**60%**

Covered Services	Optional Benefits Available		
	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)
Vision One routine eye exam per calendar year. Hardware limited to $150 per calendar year maximum benefit. Not subject to deductible.	**100%**	**100%**	**100%**

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	
Preventive Care	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).
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 24 consecutive months. There is a six-month waiting period that must be met prior to benefits being available for pre-existing conditions. Members may receive credit from prior medical coverage. Pre-existing condition waiting periods do not apply to Members up to age19.
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:

- **Complementary Care:** Including, but not limited to, the following: acupuncture, chiropractic care, massage or massage therapy and the services of an acupuncturist, a chiropractor, a massage therapist and a naturopath
- **Cosmetic/Reconstructive Services and Supplies** except for reconstruction for functional injury and disease, to treat a congenital anomaly for members up to age 18, 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
- **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
- **Non-Duplication of Medicare:** Services and supplies to the extent payable under Medicare, when by law, the plan would not be primary to Medicare had the member properly enrolled in Medicare when first eligible regardless of whether or not the member actually enrolled
- **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** including treatment of corns and calluses and trimming of nails
- **Routine Hearing Exams**
- **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 Reassignment Treatment and Surgery:** Treatment, surgery, or 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
- **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.