

# Regence HDHP-1 with Alternative Care

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Eligible Family | Plan Type: PPO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [regence.com](http://regence.com) or by calling 1 (888) 370-6159. **Please Note:** Your medical plan is issued by Regence BlueCross BlueShield of Oregon and insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

| Important Questions                                       | Answers                                                                                                                                                                                                  | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                   | <b>\$1,500</b> single / <b>\$3,000</b> family per calendar year. Doesn't apply to in-network preventive care. Amounts in excess of the <u>allowed amount</u> do not count toward the <u>deductible</u> . | Single: You must pay all the costs up to the single <u>deductible</u> amount before this plan begins to pay for covered services you use.<br>Family: Claimants collectively must pay all the costs up to the family <u>deductible</u> amount before this plan begins to pay for any claimant's covered services. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No.                                                                                                                                                                                                      | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                                                                                                                                                                                                                                                                                                                                                        |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | Yes. <b>\$2,300</b> single / <b>\$5,050</b> family* per calendar year. *A claimant on family coverage will not have his or her <u>out-of-pocket limit</u> exceed \$6,850.                                | The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.                                                                                                                                                                                                                                                                                                                                                    |
| What is not included in the <u>out-of-pocket limit</u> ?  | <u>Premiums</u> , balance-billed charges, and health care this plan doesn't cover.                                                                                                                       | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Does this plan use a <u>network of providers</u> ?        | Yes. See <a href="http://regence.com">regence.com</a> or call 1 (888) 370-6159 for lists of <u>preferred</u> or participating <u>providers</u> .                                                         | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .                                                                                           |
| Do I need a referral to see a <u>specialist</u> ?         | No. You don't need a referral to see a <u>specialist</u> .                                                                                                                                               | You can see the <u>specialist</u> you choose without permission from this plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Are there services this plan doesn't cover?               | Yes.                                                                                                                                                                                                     | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .                                                                                                                                                                                                                                                                                                                                                                                             |

**Questions:** Call 1 (888) 370-6159 or visit us at [regence.com](http://regence.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1 (888) 370-6159 to request a copy.

Claims Administrator: Regence BlueCross BlueShield of Oregon



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred** and participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event                                                                                                                      | Services You May Need                            | Your Cost If You Use a Preferred Provider                                                | Your Cost If You Use a Participating Provider                                            | Your Cost If You Use a Non-Participating Provider                                        | Limitations & Exceptions                                                                                                                                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care <b>provider's</b> office or clinic                                                                             | Primary care visit to treat an injury or illness | 20% coinsurance                                                                          | 20% coinsurance                                                                          | 40% coinsurance                                                                          | _____none_____                                                                                                                                                                                                                                                                        |
|                                                                                                                                           | Specialist visit                                 | 20% coinsurance                                                                          | 20% coinsurance                                                                          | 40% coinsurance                                                                          |                                                                                                                                                                                                                                                                                       |
|                                                                                                                                           | Other practitioner office visit                  | 20% coinsurance for alternative care – acupuncture and chiropractic spinal manipulations | 20% coinsurance for alternative care – acupuncture and chiropractic spinal manipulations | 40% coinsurance for alternative care – acupuncture and chiropractic spinal manipulations | Coverage is limited to \$1,000 for all alternative care combined per claimant / year.                                                                                                                                                                                                 |
|                                                                                                                                           | Preventive care/ screening/immunization          | No charge                                                                                | No charge                                                                                | 40% coinsurance                                                                          | No charge for childhood immunizations from non-participating <b>providers</b> .                                                                                                                                                                                                       |
| If you have a test                                                                                                                        | Diagnostic test (x-ray, blood work)              | 20% coinsurance                                                                          | 20% coinsurance                                                                          | 40% coinsurance                                                                          | _____none_____                                                                                                                                                                                                                                                                        |
|                                                                                                                                           | Imaging (CT/PET scans, MRIs)                     | 20% coinsurance                                                                          | 20% coinsurance                                                                          | 40% coinsurance                                                                          |                                                                                                                                                                                                                                                                                       |
| If you need drugs to treat your illness or condition<br><br>Your prescription drug coverage is administered through Express Scripts (ES). | Generic drugs                                    | 20% coinsurance / retail and mail order prescription                                     |                                                                                          |                                                                                          | <b>Out-of-pocket limit</b> \$2,300 / claimant / year.<br>Coverage is limited to 30-day supply retail or 90-day supply mail order.<br>Specialty drug coverage is limited to a 30-day supply.<br>Specialty medication filled at a retail pharmacy is subject to 100% <b>copayment</b> / |

| Common Medical Event                                                                                                                                                                                                                                                                                              | Services You May Need                          | Your Cost If You Use a Preferred Provider                                                                                                                 | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Please visit Express Scripts' web site at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or contact their customer service at 1 (800) 496-4182.</p> <p>Regence BlueCross Blue Shield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.</p> | Preferred brand drugs                          | 20% coinsurance / retail and mail order prescription                                                                                                      |                                               |                                                   | <p><b>coinsurance</b>, and this amount does not accumulate towards the out-of-pocket maximum.</p> <p>Certain preventive items and services as defined by the Affordable Care Act are covered at zero dollar cost share.</p> <p>Deductible waived for generic and preferred brand drugs designated as preventive for treatment of chronic diseases that are on the Preventive Medications List.</p> <p>You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the <b>copayment</b> and/or <b>coinsurance</b>, unless your <b>provider</b> specifies "dispense as written."</p> |
|                                                                                                                                                                                                                                                                                                                   | Non-preferred brand drugs                      | 20% coinsurance / retail and mail order prescription                                                                                                      |                                               |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                   | Specialty drugs                                | Refer to generic, preferred brand and non-preferred brand drugs costs above, for specialty drugs or self-administrable cancer chemotherapy drug coverage. |                                               |                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                             | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance                                                                                                                                           | 20% coinsurance                               | 40% coinsurance                                   | Coverage at a <b>preferred</b> ambulatory surgery center is 10% <b>coinsurance</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                   | Physician/surgeon fees                         | 20% coinsurance                                                                                                                                           | 20% coinsurance                               | 40% coinsurance                                   | Coverage for <b>preferred</b> ambulatory surgery center physicians is 10% <b>coinsurance</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                                                    | Emergency room services                        | 20% coinsurance                                                                                                                                           | 20% coinsurance                               | 20% coinsurance                                   | —————none—————                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                   | Emergency medical transportation               | 20% coinsurance                                                                                                                                           | 20% coinsurance                               | 20% coinsurance                                   | —————none—————                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                   | Urgent care                                    | Covered the same as the <b>If you visit a health care provider's office or clinic</b> or <b>If you have a test</b> Common Medical Events.                 |                                               |                                                   | —————none—————                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                                                                                                | Facility fee (e.g., hospital room)             | 20% coinsurance                                                                                                                                           | 20% coinsurance                               | 40% coinsurance                                   | —————none—————                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                   | Physician/surgeon fee                          | 20% coinsurance                                                                                                                                           | 20% coinsurance                               | 40% coinsurance                                   | —————none—————                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

| Common Medical Event                                                          | Services You May Need                        | Your Cost If You Use a Preferred Provider | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions                                                                                                                    |
|-------------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------|-----------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   | _____none_____                                                                                                                              |
|                                                                               | Mental/Behavioral health inpatient services  | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   |                                                                                                                                             |
|                                                                               | Substance use disorder outpatient services   | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   |                                                                                                                                             |
|                                                                               | Substance use disorder inpatient services    | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   |                                                                                                                                             |
| <b>If you are pregnant</b>                                                    | Prenatal and postnatal care                  | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   | _____none_____                                                                                                                              |
|                                                                               | Delivery and all inpatient services          | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   |                                                                                                                                             |
| <b>If you need help recovering or have other special health needs</b>         | Home health care                             | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   | Coverage is limited to 130 visits / year.                                                                                                   |
|                                                                               | Rehabilitation services                      | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   | Coverage is limited to 77 outpatient visits for all rehabilitation and habilitation services, including neurodevelopmental services / year. |
|                                                                               | Habilitation services                        | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   | Coverage for neurodevelopmental therapy is limited to services for claimants through age 17.                                                |
|                                                                               | Skilled nursing care                         | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   | Coverage is limited to 120 inpatient days / year.                                                                                           |
|                                                                               | Durable medical equipment                    | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   | _____none_____                                                                                                                              |
|                                                                               | Hospice service                              | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   | Coverage is limited to 14 respite days / lifetime.                                                                                          |
| <b>If your child needs dental or eye care</b>                                 | Eye exam                                     | Not covered                               | Not covered                                   | Not covered                                       | _____none_____                                                                                                                              |
|                                                                               | Glasses                                      | Not covered                               | Not covered                                   | Not covered                                       | _____none_____                                                                                                                              |
|                                                                               | Dental check-up                              | Not covered                               | Not covered                                   | Not covered                                       | _____none_____                                                                                                                              |

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery, except congenital anomalies
- Dental care (Adult or child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Vision hardware
- Weight loss programs, unless required by law

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care, spinal manipulations only
- Hearing aids for claimants 18 or younger or for enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution
- Non-emergency care when traveling outside the U.S.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (888) 370-6159. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1(866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1(877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (888) 370-6159 or visit [regence.com](http://regence.com). You may also contact the Division of Financial Regulation by calling (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: [www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx](http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx); or by E-mail at: [cp.ins@state.or.us](mailto:cp.ins@state.or.us) or the U.S. Department of Labor, Employee Benefits Security Administration at 1(866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (888) 370-6159.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$4,730
- **Patient pays:** \$2,810

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,500        |
| Copays               | \$0            |
| Coinsurance          | \$1,160        |
| Limits or exclusions | \$150          |
| <b>Total</b>         | <b>\$2,810</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$3,100
- **Patient pays:** \$2,300

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,500        |
| Copays               | \$0            |
| Coinsurance          | \$760          |
| Limits or exclusions | \$40           |
| <b>Total</b>         | <b>\$2,300</b> |

“Patient pays” amounts in this coverage example are based on Individual coverage. Different amounts may apply in Family coverage. Consult your plan documents for more information about your cost-sharing.

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

**✗ No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

**✗ No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

**✓ Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

**✓ Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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