Regence BlueShield: Regence Silver Connect 4000 MultiCare

Coverage Period: 01/01/2016 – 12/31/2016

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 www.Regence.com or by calling 1 (888) 344-6347.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$4,000** insured /**$8,000** family per calendar year. Out-of-network: **$8,000** insured /**$16,000** family per calendar year. Doesn't apply to generic and category 1 retail drugs, pediatric vision services, pediatric dental services and the following in-network services: certain preventive care, primary care and urgent care office visits, diagnostic x-ray/laboratory services and outpatient mental health and substance abuse. **Copayments** and amounts in excess of the **allowed amount** do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-network: **$6,850** insured / **$13,700** family per calendar year. Out-of-Network: **$20,550** insured / **$41,100** family per calendar year.	The **out-of-pocket limit** 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 out-of-pocket limit?	**Premiums**, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.Regence.com or call 1 (888) 344-6347 for lists of in-network or out-of-network **providers**.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** 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 **excluded services**.

- **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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit, other services 50% coinsurance	50% coinsurance	**Copayment** applies to each in-network office visit only, **deductible** waived. All other services are covered at the **coinsurance** specified, after **deductible**.
	Specialist visit	$50 copay / visit, other services 50% coinsurance	50% coinsurance	
	Other practitioner office visit	50% coinsurance	50% coinsurance	Coverage is limited to 12 acupuncture visits / year. Coverage is limited to 10 spinal manipulations / year.
	Preventive care/ screening/immunization	No charge	50% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	50% coinsurance	**Deductible** waived for in-network diagnostic x-ray and laboratory services.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is	Generic drugs	$10 copay* / generic retail prescription $20 copay / generic mail order prescription $10 copay / generic self-administrable cancer chemotherapy drug prescription		No coverage for prescription drugs not on the Essential Formulary or prescription drugs from an out-of-network pharmacy. Coverage is limited to a 90-day supply retail (1 copay per 30-day supply) or mail order.
	Preferred brand drugs	$50 copay** / category 1 retail prescription $100 copay / category 1 mail order prescription		

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
available at https://www.regence.com/web/regence_individual/pharmacy.		$50 copay / category 1 self-administrable cancer chemotherapy drug prescription		Coverage is limited to a 30-day supply for injectable drugs, specialty drugs and self-administrable cancer chemotherapy drugs. **Deductible** waived for generic drugs and category 1 formulary brand drugs and immunizations at a participating pharmacy. No charge for FDA-approved women's contraceptives prescribed by a health care **provider**. Coverage includes generic tobacco use cessation drugs when obtained with a prescription order. The first fill is allowed at a retail pharmacy for specialty drugs. Additional fills must be provided at a specialty pharmacy. Specialty self-administrable cancer chemotherapy drugs must be purchased at a specialty pharmacy. *You can receive a $5 discount if filled at a Preferred Pharmacy. **$5 discount if filled at a Preferred Pharmacy. ***5% discount if filled at a Preferred Pharmacy.
	Non-preferred brand drugs	50% coinsurance*** / category 2 retail prescription 40% coinsurance / category 2 mail order prescription 50% coinsurance / category 2 self-administrable cancer chemotherapy drug prescription		
	Specialty drugs	40% coinsurance / specialty drug prescription 40% coinsurance / specialty self-administrable cancer chemotherapy drug prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance for ambulatory surgery centers; 50% coinsurance for other facilities	50% coinsurance	——————none——————
	Physician/surgeon fees	40% coinsurance for ambulatory surgery centers; 50% coinsurance for other facilities	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	50% coinsurance		——————none——————
	Emergency medical transportation	50% coinsurance		——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Urgent care	$50 copay / visit, other services covered the same as the **If you have a test** Common Medical Events.	50% coinsurance	**Copayment** applies to each in-network urgent care visit only, **deductible** waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fee	50% coinsurance	50% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay / visit	50% coinsurance	**Copayment** applies to each in-network outpatient therapy visit only, **deductible** waived.
	Mental/Behavioral health inpatient services	50% coinsurance	50% coinsurance	
	Substance use disorder outpatient services	$20 copay / visit	50% coinsurance	
	Substance use disorder inpatient services	50% coinsurance	50% coinsurance	
If you are pregnant	Prenatal and postnatal care	50% coinsurance	50% coinsurance	——————none——————
	Delivery and all inpatient services	50% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	Coverage is limited to 130 visits / year.
	Rehabilitation services	50% coinsurance	50% coinsurance	Coverage is limited to 30 inpatient days / year. Coverage is limited to 25 outpatient visits / year.
	Habilitation services	50% coinsurance	50% coinsurance	Coverage for habilitative services is limited to 30 inpatient days / year. Coverage for habilitative services is limited to 25 outpatient visits / year. Coverage for neurodevelopmental therapy is limited to 25 outpatient visits / year.
	Skilled nursing care	50% coinsurance	50% coinsurance	Coverage is limited to 60 inpatient days / year.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Durable medical equipment	50% coinsurance	50% coinsurance	————————none————————
	Hospice service	50% coinsurance	50% coinsurance	Coverage is limited to 14 respite days / lifetime.
If your child needs dental or eye care	Eye exam	No charge	No charge	Coverage is limited to insureds under the age of 19. Coverage is limited to one routine exam / year.
	Glasses	No charge	No charge	Coverage is limited to insureds under the age of 19. Coverage is limited to one pair of lenses (2 lenses) and one frame / year.
	Dental check-up	No charge	No charge	Coverage for preventive and diagnostic examinations is limited to 2 each per insured / year for insureds under age 19. Additional coverage is provided for basic and major pediatric dental services.

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.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long–term care
- Private–duty nursing
- Routine eye care (Adult)
- Routine foot care
- Vision hardware (Adult)
- Weight loss programs

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
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Termination of pregnancy

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside of the coverage area

For more information on your rights to continue coverage, contact the plan at 1 (888) 344-6347. You may also contact your state insurance department at 1 (800) 562-6900 or www.insurance.wa.gov.

Your Grievance and Appeals Rights:

- Contact the Washington State Office of the Insurance Commissioner at 1 (800) 562-6900 or www.insurance.wa.gov.

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) 344-6347.

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

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:** $1,740
- **Patient pays:** $5,800

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
Total	**$7,540**

Patient pays:

Deductibles	$4,000
Copays	$20
Coinsurance	$1,630
Limits or exclusions	$150
Total	**$5,800**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,150
- **Patient pays:** $2,250

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
Total	**$5,400**

Patient pays:

Deductibles	$420
Copays	$1,790
Coinsurance	$0
Limits or exclusions	$40
Total	**$2,250**

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.

Regence BlueShield: Adult Dental and Vision

Coverage Period: 01/01/2016 – 12/31/2016

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

Coverage for: Individual & Eligible Family

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 www.Regence.com or by calling 1 (888) 344-6347.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$50** insured / **$150** family per calendar year for dental services. Doesn't apply to preventive dental services and vision benefits. **Coinsurance** or amounts in excess of the **allowed amount** do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered dental services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	Yes. Dental: **$750** Vision: **$150** for hardware	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits. **Dental Rewards:** You have the opportunity to add $250 to the overall dental annual limit if you used less than the overall annual limit for covered services in the first calendar year. At no time will the accumulated dental overall annual limit be more than $1,500 for a calendar year.
Does this plan use a network of providers?	Yes. See www.Regence.com or call 1 (888) 344-6347 for lists of in-network or out-of-network **providers**.	If you use an in-network dental **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in–network dental **provider** may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 1 (888) 344-6347 or visit us at www.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 or call 1 (888) 344-6347 to request a copy.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the dental services this plan doesn't cover are listed on page 3. See your policy or plan document for additional information about **excluded services**.

- **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 a crown is $500, your **coinsurance** payment of 50% would be $250. 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 dentist charges $200 for an examination and the **allowed amount** is $150, you may have to pay the $50 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Dental Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have preventive dental services	Cleanings and examinations	No charge	No charge	Coverage is limited to 2 cleanings and 2 preventive oral examinations / year, **deductible** waived.
	X-rays	No charge	No charge	Coverage is limited to 2 bitewing x-ray series / year. Coverage is limited to 1 complete intra-oral mouth and 1 panoramic mouth x-rays once in a 3 year period. **Deductible** waived.
If you need basic dental services	Periodontal services	20% coinsurance	20% coinsurance	Coverage is limited to 1 per quadrant in a 3 year period for complex periodontal surgical procedures. Coverage is limited to 2 periodontal maintenance / year (in lieu of preventive cleanings). Coverage is limited to 1 periodontal debridement in a 3 year period. Coverage is limited to 1 per quadrant in a 2 year period for periodontal scaling and root planing.
	Endodontic services	20% coinsurance	20% coinsurance	——————none——————

Common Dental Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Emergency and other basic dental services	20% coinsurance	20% coinsurance	————————none————————
If you need major dental services	Bridges	50% coinsurance	50% coinsurance	Coverage is limited to replacement bridges once per 7 years after placement.
	Crowns, inlays and onlays	50% coinsurance	50% coinsurance	Coverage is limited to replacement crowns, inlays or onlays once per tooth, 7 years after placement.
	Dentures (full and partial)	50% coinsurance	50% coinsurance	Coverage is limited to 1 per arch in a 3 year period for denture rebase and denture relines. Coverage is limited to replacement dentures 7 years after placement.
	Implants (endosteal)	50% coinsurance	50% coinsurance	Coverage is limited to 4 endosteal implants / lifetime.

Excluded Services:

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

- Aesthetic dental procedures
- Cosmetic/reconstructive services and supplies, except congenital anomalies
- Duplicate x-rays
- Facility charges
- Gold-foil restorations
- Implants (non-endosteal)
- Nitrous Oxide
- Occlusal treatment
- Orthodontic services
- Orthognathic surgery
- Temporomandibular joint (TMJ) Dysfunction Treatment
- Tooth transplantation
- Veneers

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered vision 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 a vision examination is $50, your **coinsurance** payment of 20% would be $10. 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 **provider** charges $150 for a vision examination and the **allowed amount** is $50, you may have to pay the $100 difference. (This is called **balance billing**.)

Common Vision Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit an eye care provider's office or clinic	Routine vision examination	No charge	No charge	Coverage is limited to one routine eye exam per member per calendar year.
	Vision hardware	No charge up to $150 hardware maximum	No charge up to $150 hardware maximum	Coverage is limited to $150 for covered vision hardware per calendar year and you pay any balance.

Excluded Services:

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

- Contact fittings
- Cosmetic services and supplies
- Fees, taxes, interest
- Medical services
- Non-direct patient care
- Personal comfort items
- Prescription medication
- Vision therapy and surgery