Regence HSA Comprehensive Healthplan

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

Regence BlueCross BlueShield of Oregon

Your Regence HSA (Health Savings Account) Comprehensive Healthplan provides coverage for services provided by In-Network and Out-Of-Network physicians and other professional providers as listed below. Once enrolled, the **Participating Network** is the panel of providers for which you will receive the greatest benefits. For assistance in locating an In-Network physician or provider please refer to your provider directory or visit our Web site at **www.or.regence.com**.

Please note: This benefit summary provides a brief description of your health care plan benefits and it not a guarantee of payment. Please refer to your contract for a complete list of benefits and the limitations and exclusions that apply.

Benefit Features	In-Network Benefit	Out-Of-Network Benefit
Lifetime maximum benefit	$2,000,000	
Deductible options per calendar year	$1,500 single coverage / $3,000 family coverage	
Out-of-pocket maximum amount per calendar year including deductible	$5,000 single coverage $10,000 family coverage	None
After the out-of-pocket maximum is met each calendar year, we pay	100%	N/A
Please note: Single coverage deductible and out-of-pocket maximum applies when an individual is enrolled without dependents. Family coverage deductible and out-of-pocket maximum applies when an individual and one or more dependents are enrolled. Prior to benefits being paid, the entire family deductible must be met.		
Preventive Care Services	**Deductible Waived - We Pay**	
Immunizations for adults and children	80%	60%
Well-baby and well child care including related lab & x-ray services	80%	60%
Women's exams including Pap tests and mammograms	80%	60%
Adult routine physical exams including related lab & x-ray services	80%	60%
Professional Services	**After Deductible - We Pay**	
Office visits and other office procedures, including outpatient treatment for mental illness	80%	60%
Therapeutic injections including allergy shots	80%	60%
Maternity care	80%	60%
Surgery	80%	60%
Diagnostic radiology and lab	80%	60%
Hospital Services	**After Deductible - We Pay**	
Emergency room care for medical emergency	80%	
Emergency room care for non-emergency	80%	60%
Inpatient stay including surgery , maternity, rehabilitation, mental illness	80%	60%
Outpatient services including surgery, diagnostic radiology, and lab	80%	60%
Other Services	**After Deductible - We Pay**	
Ambulance	80%	
Outpatient rehabilitation (physical, speech, and occupational therapy)	80%	60%
Skilled nursing facility, home health, and hospice care	80%	60%
Durable medical equipment and supplies	80%	60%
Neurodevelopmental therapy	80%	60%
Prescription Benefits	**After Deductible - We Pay**	
Pharmacy purchased prescription medications (30-day supply)	50%	

Additional Benefits and Information	
BlueCard® program	Provides savings nationwide by using Participating providers of the Blue Cross and/or Blue Shield Plan in the area where you receive the service. Using providers outside of the Blue Cross and/or Blue Shield Plan may likely result in greater out of pocket expenses. Find a provider near you at **www.bcbs.com**.
myRegence.com	**myRegence.com** is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to **www.myRegence.com** and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.

Please see page 2 for limitations and exclusions >

Limitations and Exclusions

This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. Please refer to your contract for a complete list of benefits and the limitations and exclusions that apply. Once enrolled, your contract can be viewed online at our Web site, **www.or.regence.com.**

Prostate and Colorectal Cancer Screening

Covered services include medically necessary prostate and colorectal cancer screenings. Please refer to your contract for how cancer screenings are covered.

These Benefits Are Limited

- We provide transplant coverage only to those who have been covered by us, or another insurer with similar transplant coverage, for a total of at least 12 months (or since birth). Please refer to your contract for details on creditable coverage. Benefits are based on the recipient's eligibility, not the donor's. Our payment for all covered transplant services and supplies is limited to a lifetime maximum of $350,000 per enrollee. Covered services and supplies for the first 90-day period following the transplant will accrue towards the transplant lifetime maximum.
- Emergency care covered services include the medical examination and ancillary tests required in determining the extent of an emergency medical condition. Examples include but are not limited to: Suspected heart attach, serious burn, loss of consciousness, poisoning, bleeding that does not stop and severe pain.
- Acupuncture is limited to 12 treatments per calendar year.
- Spinal manipulation is limited to 10 treatments per calendar year.
- Inpatient rehabilitation care is limited to $15,000 per calendar year.
- Outpatient rehabilitation care including massage therapy is limited to $1,500 per calendar year.
- Neurodevelopmental therapy is limited to $1,500 per calendar year for children age 6 and under.
- Home health care is limited to 130 visits per calendar year.
- Skilled nursing facility care is limited to 100 days per stay.
- Durable medical equipment is limited to $2,500 per calendar year. The yearly maximum for durable medical equipment and supplies does not apply to diabetic equipment and supplies.
- Ground and air ambulance combined is limited to $5,000 per calendar year (does not apply to emergent use).
- Dental care is limited to the treatment of an accidental injury to natural teeth or fractured jaw and limited to $1,000 per calendar year. Diagnosis must be made within 6 months and treatment within 12 months of injury.
- Hospitalization for medically necessary dental care is limited to $1,000 per calendar year.
- Growth hormone benefit, when eligible according to the contract, is limited to $20,000 per calendar year.
- The following will be covered only after nine months of enrollment: preexisting conditions, allergies, otitis media (ear infections), removal of tonsils and adenoids and sterilization procedures. You may receive credit from prior creditable medical coverage, providing there is a less than 63-day lapse between the two coverages.

Services And Supplies Not Covered

- Immunizations for the sole purpose of travel or passport purposes.
- Services provided by a member of your immediate family.
- Services or supplies that are not medically necessary.
- Chemical dependency.
- Services related to or supporting infertility and reversal of sterilization procedures.
- Orthognathic surgery.
- Temporomandibular joint disorder.
- Custodial care, personal hygiene, and other forms of supervised self-care.
- Services and supplies provided for obesity or weight reduction, including complications arising from such treatment.
- Chronic or long-term psychotherapy (services provided in excess of crisis intervention or short-term therapy).
- Services or supplies for the treatment of personality and gender identity disorders.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Experimental and investigational treatment, procedures, equipment, devices, and supplies.
- Treatment for addiction to tobacco, tobacco products, nicotine substitutes, or foods.
- Appliances or equipment primarily for personal comfort or convenience, and therapeutic devices including eyeglasses and hearing aids.
- Routine physical, mental, eye, hearing examinations, or eye exercises (except where specifically listed).
- Surgery to alter the refractive character of the eye.
- Off-the-shelf orthotics or orthotics that are not medically necessary.
- Self-help training, instructional programs, and physical exercise programs (except where specifically listed).

These Pharmacy Benefits Are Limited

- The maximum quantity for pharmacy purchased medications is a 30-day supply.
- Compound medications are only covered when one ingredient is a federal legend or state restricted medication.

These Pharmacy Benefits Are Not Covered

- Impotence and infertility medications.
- Experimental/investigational medications.
- Medications prescribed for cosmetic purposes.
- Smoking cessation products.

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Toll-free, all areas 1 (800) 365-3155
TDD Line for people with hearing impairments 1 (800) 382-1003
www.or.regence.com