CLARK COUNTY
STAFF REPORT

DEPARTMENT: Human Resources

DATE: November 26, 2019

REQUEST: Approve Regence Contract Renewal

CHECK ONE: X Consent _____ CAO

BACKGROUND

The rates for the Regence Preferred Provider Plan came in very favorable with a 0% rate increase. We have approximately 733 employees covered by this plan. In accordance with the Affordable Care Act, the out-of-pocket maximum will be stated as $2,800 per year for an individual or $5,600 for a family with copays (office visit and Rx), the deductible and coinsurance applying to the maximum. This is a change from the current plan design of a $300 deductible and $2,500 out of pocket maximum with only the 15% coinsurance applying; the combination of the $300 plus $2,500 results in $2,800 total out of pocket. A copy of the Plan Summary is included which shows the coverage by type of service.

In 2014, we are implementing a new High Deductible Health Plan. The addition of this plan will help curb health care costs in the future and meets the Affordable Care Act requirement to offer an affordable health plan. This plan includes a $1,250 deductible or $2,500 for family; once met the plan pays 80% up to a $3,000 individual or $6,000 family out of pocket maximum. A copy of the Plan Summary is included your review. The cost of this plan is approximately 14.5% less than the Preferred Provider Plan.

COMMUNITY OUTREACH

Community Outreach is not a consideration; this is an internal matter.

BUDGET AND POLICY IMPLICATIONS

Since the rates did not increase for 2014, any additional cost for this benefit would result merely from enrollment changes.

FISCAL IMPACTS

☑ **Yes (see attached form)** ☐ **No**

ACTION REQUESTED

Approve Contract Amendment to renew the Regence Preferred Provider Plan and the High Deductible Health Plan for plan year 2014.

DISTRIBUTION

Kathy Meyers, Benefits Manager

Francine Reis
Human Resources Director

Approved: _____
CLARK COUNTY
BOARD OF COMMISSIONERS

NOV. 26, 2013 SR 234-13

Part II: Estimated Revenues

Fund #/Title	Current Biennium		Next Biennium		Second Biennium	
	GF	Total	GF	Total	GF	Total
8999/Benefits Clearing	$164,659	$225,312				
Total	$164,659	$225,312				

II. A – Describe the type of revenue (grant, fees, etc.)

Premium collected from the departments across all funds, and employee contributions.

Part III: Estimated Expenditures

III. A – Expenditures summed up

The expenditures represent the enrollment times the rates. The rates did not increase thus any change is a result of changes in enrollment. The High Deductible Health Plan was not factored into the amount as an assumed enrollment was not considered.

Fund #/Title	FTE's	Current Biennium		Next Biennium		Second Biennium	
		GF	Total	GF	Total	GF	Total
Across all funds		$164,659	$225,312				
Total		$164,659	$225,312				

III. B – Expenditure by object category

Fund #/Title	Current Biennium		Next Biennium		Second Biennium	
	GF	Total	GF	Total	GF	Total
Salary/Benefits	$164,659	$225,312				
Contractual						
Supplies						
Travel						
Other controllables						
Capital Outlays						
Inter-fund Transfers						
Debt Service						
Total	$164,659	$225,312				

Group Name:	Clark County	**Enrollment (EE's):**	840
Group Number:	60019995	**Enrollment (Mbr's):**	2,250
Effective Date:	1/1/2014	**Medical Funding:**	Fully Insured
Contract Issuance:	Clark County	**Pharmacy Funding:**	Fully Insured
Account Executive:	Kara Jolliffe-Buck	**Status:**	Not Grandfathered
Large Group Coordinator:	N/A	**Sales Specialist:**	Laura Odoms
Sales Opportunity #:	8794186		

MEDICAL	Active Employees	DSG/Custody	Medical Plan 3			
Core Contract	Lg Grp PPO	Lg Grp PPO	HSA Healthplan 2.0			
Deductible	$300	$300	$1,250/$2,500			
Coinsurance Maximum	$2,800	$2,800	$3,000/$6,000			
Coinsurance % - Category 1	85%	85%	80%			
Coinsurance % - Category 2	50%	50%	60%			
Coinsurance % - Category 3	50%	50%	60%			
Category 1 Network	Regence PPO	Regence PPO	Regence PPO			
Category 2 Network	Traditional	Traditional	Traditional			
Office Visit Copay	$20 / None	$20 / None	N/A			
Upfront Visit Limit	N/A	N/A	N/A			
PHARMACY						
Deductible	$0	$0	Shared w/Medical			
Coinsurance Max / Out of Pocket	Shared w/Medical	Shared w/Medical	Shared w/Medical			
Rewards Based Benefit	Excluded	Excluded	Excluded			
Generics	$10	$10	20%			
Brand Formulary	$20	$20	20%			
Brand Non-formulary	$30	$30	20%			
MAC	MAC C	MAC C	MAC C			
MEDICAL OPTIONAL BENEFITS						
Regence Vision Exam	Not Covered	Not Covered	Not Covered			
Regence Vision Hardware - per Year	Not Covered	Not Covered	Not Covered			
MEDICAL PLAN DETAIL (Illustrates Category 1 level coinsurance)						
Annual Maximum	Unlimited	Unlimited	Unlimited			
Family Mbrs to Meet Deductible	2	2	N/A			
Family Mbrs to Meet Coinsurance Max	2	2	N/A			
Acupuncture	Unlimited	Unlimited	Unlimited			
Ambulance Services	85%	85%	80%			
Chemical Dependency	85%	85%	80%			
Durable Medical Equip	Unlimited	Unlimited	Unlimited			
Emergency Room - Copay	$100	$100	N/A			
Genetic Testing	Unlimited	Unlimited	Unlimited			
Home Health - visits per year	Unlimited	Unlimited	Unlimited			
Hospice - Respite Days per Lifetime	Unlimited	Unlimited	Unlimited			
Hospital Inpatient Services	85%	85%	80%			
Maternity	85%	85%	80%			
Mental Health	85%	85%	80%			
Neurodevel. Therapy - Visits per year	Unlimited	Unlimited	Unlimited			
Nutritional Counseling - Lifetime Visits	Unlimited	Unlimited	Unlimited			
Orthotics	Unlimited	Unlimited	Unlimited			
Preventive Services/Immunizations	100%	100%	100%			
Prosthesis	Unlimited	Unlimited	Unlimited			
Radiology & Lab - OutP	100%	100%	80%			
Rehabilitation - InP Days per Year	Unlimited	Unlimited	Unlimited			
Rehabilitation - OutP Visits per Year	Unlimited	Unlimited	Unlimited			
Skilled Nursing Fac - Days per Year	Unlimited	Unlimited	Unlimited			
Spinal Manipulations - per Year	Unlimited	Unlimited	Unlimited			
TMJ (Medical)	Unlimited	Unlimited	Unlimited			
Transplants - Donor Limit	Unlimited	Unlimited	Unlimited			
Transplants	Unlimited	Unlimited	Unlimited			
VARIATIONS FROM CORE MEDICAL/PHARMACY CONTRACT FOR SELECTED PLANS						

Acupuncture: not subject to deductible category 1
Active Employees, DSG/Custody

Allergy: » testing and injections not subject to deductible category 1
Active Employees, DSG/Custody

Chemical Dependency: outpatient not subject to deductible category 1/2.
Active Employees, DSG/Custody

Hearing Aids: not subject to deductible Category 1/2/3, 100% coinsurance category 1, 100% coinsurance category 2, 100% coinsurance category 3
Active Employees, DSG/Custody

Hearing Exam: not subject to deductible Category 1. Subject to deductible and coinsurance Category 2/3. Routine hearing exam covered once per calendar year.
Active Employees, DSG/Custody

Infertility (diagnosis and treatment only): covered subject to deductible and coinsurance
Active Employees, DSG/Custody

VARIATIONS FROM CORE MEDICAL/PHARMACY CONTRACT FOR SELECTED PLANS

Maternity: dependent daughter is covered
Active Employees, DSG/Custody

Mental Health: outpatient not subject to deductible category 1/2
Active Employees, DSG/Custody

Office Visits: not subject to deductible Category 1, 100% coinsurance category 1
Active Employees, DSG/Custody

Outpatient Radiology & Lab: not subject to deductible Category 1
Active Employees, DSG/Custody

Pharmacy Drug Specific: » $0 copay for generic and brand value based medications
Active Employees

Pharmacy Drug Specific: » $0 copay for generic value-based medications
Active Employees

Pharmacy Drug Specific: » Pharmacy coordination of benefits applies
Active Employees, DSG/Custody

Pharmacy Retail v. Mail-Order: 2X copay for 90-day mail-order
Active Employees, DSG/Custody

Pharmacy: Value based Rx applies
Medical Plan 3

Preventive Services/Immunizations: not subject to deductible Category 3, 100% coinsurance category 3
Active Employees, DSG/Custody

Rehabilitation, Outpatient: not subject to deductible Category 1
Active Employees, DSG/Custody

Spinal Manipulation: not subject to deductible Category 1
Active Employees, DSG/Custody

Group Name:	Clark County	**Enrollment (EE's):**	840
Group Number:	60019995	**Enrollment (Mbr's):**	2250
Effective Date:	1/1/2014	**Dental Funding:**	N/A
Contract Issuance:	Clark County		

PROGRAMS AND SERVICES						
Programs embedded in plan(s): Integrated Care Management; Rare Disease Management; Care Enhance Nurse Line						
Optional programs selected: Vitality						
Optional services selected: none						
STOP LOSS	**Stop Loss Plan 1**					
Specific Deductible	$175,000					
Specific Incurred/Paid Basis	Paid in 12					
Specific Coverages	M,Rx					
Aggregate Incurred/Paid Basis						
Aggregate Corridor	125%					
Aggregate Coverages						
Other						
DENTAL						
Core Contract						
Deductible						
Family Mbrs to Meet Deductible						
Annual Benefit Maximum						
Preventive & Diagnostic Services						
Basic Services						
Major Services						
Orthodontia Maximum						
Orthodontia Age Limit						
TMJ (Temporomanibular Joint)						
VARIATIONS FROM CORE DENTAL CONTRACT FOR SELECTED PLANS						

SIGNATURE

The administration and benefits listed on these pages represent the plans to be administered.

Group Authorized Signature: _____

Official Title: _____

Signature Date: _____

Other Plan Provisions

Administrative

Benefits Administration

0 Pre-Existing Waiting Period for Members Age 19 and Over (months)

0 Transplant Waiting Period (months)

Custom Materials and Information

☑ Custom Benefit Booklet

Other

☑ PPO Suitcase

☑ Regardless of what day a newborn/adoptee is added, premium will not be charged until the first of date of birth/adoption) - If a member dies, full premium is charged for the month.

Eligibility

General

☑ Group Determines Its Own Eligibility According to the Plan Contract

Dependents

☑ Group Allows Domestic Partner Coverage

- ☑ Registered and Non-Registered
- ☑ Domestic Partners Eligible for COBRA

Retirees

☑ Non-Medicare Eligible (Early) Retirees are Eligible

Other

☑ Group determines own eligibility EXCEPT incapacitated dependents

☑ Pro-rating does not apply (for death, newborns/adoptions, etc.)

☑ Termination of domestic partner: One year waiting period to file another affidavit of DP

☑ If you die, coverage for your enrolled dependents is extended to end on the last day of the following month after which your death occurs

☑ For a newly eligible spouse, coverage will begin on the first of the month following the date of the qualifying event

Financial

Special Billing & Payments

☑ ACH/Wire Transfer for Payments to Regence or Asuris

Non-Standard Commission

☑ Consultant Only

Provider Reimbursement / Networks

Custom Alpha Prefix & Plan(s)

☑ KQT - All Plans

Group Name: **Clark County**
Funding Arrangement: **Prospective**
Contract Period: January 1, 2014 thru December 31, 2014
Grandfathered Status: Non Grandfathered

Actives & PERS Pre 65 Retirees Rates	Employee Only	Employee & Spouse	Employee & Child	Employee & Children	Employee & Family
Medical	$549.02	$1,092.58	$1,092.58	$1,537.30	$1,537.30
Pharmacy	$101.64	$202.26	$202.26	$284.54	$284.54
Total Rate	**$650.66**	**$1,294.84**	**$1,294.84**	**$1,821.84**	**$1,821.84**

Actives & PERS Pre 65 Retirees Benefit Description

Medical	Lg Grp PPO: $300 Ded; $20 OV; 85/50; $2,800 med/rx combined OOP; Chiro, Acupuncture, Naturopaths, Vitality
Pharmacy	Rx: $10/$20/$30; MO 2x; Value Based Rx; OOP combined with medical

Deputy Sheriffs' - Actives & Pre 65 Retirees Rates	Employee Only	Employee & Spouse	Employee & Child	Employee & Children	Employee & Family
Medical	$549.02	$1,092.58	$1,092.58	$1,537.30	$1,537.30
Pharmacy	$101.04	$201.06	$201.06	$282.84	$282.84
Total Rate	**$650.06**	**$1,293.64**	**$1,293.64**	**$1,820.14**	**$1,820.14**

Deputy Sheriffs' - Actives & Pre 65 Retirees Benefit Description

Medical	Lg Grp PPO: $300 Ded; $20 OV; 85/50; $2,800 med/rx combined OOP; Chiro, Acupuncture, Naturopaths, Vitality
Pharmacy	Rx: $10/$20/$30; MO 2x; OOP combined with medical

Dual Option HDHP	Employee Only	Employee & Spouse	Employee & Child	Employee & Children	Employee & Family
Medical / Rx	$568.24	$1,130.82	$1,130.82	$1,591.10	$1,591.10
Total Rate	**$568.24**	**$1,130.82**	**$1,130.82**	**$1,591.10**	**$1,591.10**

Dual Option HDHP Benefit Description

Medical / Rx	HSA: $1,250 Ded; $3,000 med/rx OOP max; 80%; Value Rx with $500/$1,000 HSA Fund

Signature

The rates and benefits listed on these pages represent the rates and benefits to be administered.

Group Authorized Signature: _____

Official Title: _____

Signature Date: _____

Renewal Assumptions and Conditions

Group Name: Clark County
Group Id: 60019995
Rates Effective: January 1, 2014 through December 31, 2014

1. All rates are guaranteed for the twelve month period beginning January 1, 2014 through December 31, 2014, except in the case of:
   * Government mandated benefit change;
   * New or revised government taxes;
   * An amendment of the benefit plan or contract;
   * Any change in the type or number of reports received by the broker/Group;
   * Addition or deletion of a subsidiary, corporate divisions, or affiliated companies;
   * Any change in employer contribution, employee eligibility, or probationary period; or
   * Enrollment change of +/- 10%, based on an assumed enrollment shown below. (This includes changes within any census category as well as movement between programs.)
2. The census used in the rate calculation follows:
   Medical 830 Subscribers, 2196 Members
3. Dependent eligibility must flow through the enrolled subscriber.
4. Rates within this offer are based on the employer contributing 100% of the employee rate and 100% of the dependent rate.
5. Minimum participation is 75% of eligible employees.
6. All rates released in this renewal assume Regence and Kaiser are the only carriers for the Group's healthcare coverage.
7. At least 50% of the enrolled employees must reside in the areas serviced by Cambia.
8. Rates exclude broker commission.
9. This renewal assumes the Group is continuing the current benefit plan. In the event the Group desires a change to the current benefit plan, Regence reserves the right to re-evaluate our position.
10. No member is allowed to opt off coverage in lieu of compensation.
11. The quoted rates assume that Regence will not be subject to the benefit or administrative mandates of any other state. In the event that a benefit or administrative mandate is applicable or imposed upon us, we reserve the right to immediately re-evaluate our underwriting position.
12. The rates assume a true employee/employer relationship and that Regence would be contracting with one legal entity. Prior to enrollment, proof may be required documenting that this group is one legal contracting entity.
13. Employer must disclose to Regence any policies that would offset the member's deductible and/or coinsurance. Regence reserves the right to adjust rates accordingly.
14. Minimum enrollment on any one option for dual option benefits is 15% of total enrollment.
15. If multiple options are implemented without a qualified HDHP, the high option rate can be no more than 15% higher than the low option rate.
16. If multiple options are implemented with a qualified HDHP, the high option rate can be no more than 30% higher than the HDHP rate.
17. Regence Underwriting guidelines apply.
18. The Contract states all the terms of coverage and supersedes and cancels all and any prior contracts issued to the Group by Regence.
19. No modifications of or additions to the Contract will be binding upon Regence unless set forth in an amendment, endorsement, or rider issued by Regence and signed by one of Our authorized officers.
20. Acceptance of this offer (with or without changes) is required no later than 15 days prior to the effective date. No retroactive changes are allowed. Our offer expires 30 days from the release date. The Group's master application must be completed, signed by the Group or group representative, and submitted to Underwriting for review no later than 15 days prior to the effective date of the contract. Failure to provide complete, signed paperwork in a timely manner will result in non-issuance of the contract.
21. Regence reserves the right to rerate if any of these assumptions are changed.

22. Effective September 23, 2010, the Patient Protection and Affordable Care Act prohibits employers from discriminating in favor of highly compensated individuals as set forth in Internal Revenue Code section 105(h) and implementing regulations. Regence is unable to determine whether a plan discriminates in a way that violates the new law because it does not have access to information such as corporate structure, employee salaries, stock ownership, length of service, percentage of premiums paid by the employer, etc. Because the new law imposes fines on employers with discriminatory plans, Regence recommends that employers obtain tax and/or legal advice to ensure they comply with nondiscrimination requirements.

EMPLOYER ACCEPTANCE
I acknowledge that this document includes all selected benefit options and rates associated with these benefits.
Authorized Signature: _____
Date: _____

Regence BlueCross BlueShield of Oregon: HSA 2.0

Coverage Period: 01/01/2014 - 12/31/2014

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.myRegence.com or by calling 1 (877) 508-7357.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,250** single / **$2,500** family per calendar year. Doesn't apply to certain preventive care. Amounts in excess of the **allowed amount** do not count toward the **deductible**.	Single: You must pay all the costs up to the single **deductible** amount before this plan begins to pay for covered services you use. Family: Members collectively must pay all the costs up to the family deductible amount before this plan begins to pay for any member's covered services. 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. **$3,000** single / **$6,000** 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.myRegence.com or call 1 (877) 508-7357 for lists of **preferred** or participating **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 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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	40% coinsurance	none
	Specialist visit	20% coinsurance	40% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance for acupuncture and spinal manipulations	40% coinsurance for acupuncture and spinal manipulations	40% coinsurance for acupuncture and spinal manipulations	none
	Preventive care/ screening/immunization	No charge	No charge	40% co-insurance	**Deductible** waived.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	40% coinsurance	none
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	40% coinsurance	

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.RegenceRx.com.	Generic drugs	20% coinsurance / retail and mail order prescription			Coverage is limited to a 90-day supply from either a retail or mail order supplier. Coverage is limited to a 30-day supply for self-injectable medications from either retail or mail order supplier. **Deductible** does not apply to certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. **Deductible** waived for generic and preferred brand drugs designated as preventive for: asthma, diabetes, high blood pressure, high cholesterol or tobacco addiction.
	Preferred brand drugs	20% coinsurance / retail and mail order prescription			
	Non-preferred brand drugs	20% coinsurance / retail and mail order prescription			
	Specialty drugs	Refer to generic, preferred brand and non-preferred brand drugs above, for self-administrable cancer chemotherapy drug coverage.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	40% coinsurance	none
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	none
If you need immediate medical attention	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 **If you visit a health care provider's office or clinic** or **If you have a test** Common Medical Events.			none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	none
	Physician/surgeon fee	20% coinsurance	40% 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
If you have mental health, behavioral health, or substance abuse needs	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	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	40% coinsurance	Maternity services for children are not covered.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Habilitation services	20% coinsurance	40% coinsurance	40% coinsurance	Coverage for neurodevelopmental therapy is limited to services for members through age 6.
	Skilled nursing care	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Hospice service	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	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.)

- 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 except for diabetic patients
- Weight loss programs except for nutritional counseling
- Vision hardware

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.

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 (877) 508-7357. 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, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or 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 (877) 508-7357 or visit www.myRegence.com. You may also contact your state insurance department at 1 (800) 562-6900 or www.insurance.wa.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (877) 508-7357.

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 (877) 508-7357.

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** $4,930
- **Patient pays** $2,610

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	$1,250
Copays	$0
Coinsurance	$1,210
Limits or exclusions	$150
Total	**$2,610**

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

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

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	$1,250
Copays	$0
Coinsurance	$810
Limits or exclusions	$40
Total	**$2,100**

"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.

Regence BlueCross BlueShield of Oregon: Preferred

Coverage Period: 01/01/2014 - 12/31/2014

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.myRegence.com or by calling 1 (888) 367-2116. (Note: the Uniform Glossary can be accessed at: www.cciio.cms.gov.)

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** member / **$600** family per calendar year. Doesn't apply to certain preventive care. **Copayments** 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 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. **$2,800** member / **$5,600** family per calendar year. Your medical and prescription **out-of-pocket limit** is combined.	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.myRegence.com or call 1 (888) 367-2116 for lists of **preferred** or participating **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 **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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit	50% coinsurance	50% coinsurance	**Copayment** applies to each **preferred** office visit only, **deductible** waived. All other services are covered at the **coinsurance** specified, after **deductible**.
	Specialist visit	$20 copay / visit	50% coinsurance	50% coinsurance	
	Other practitioner office visit	15% coinsurance for acupuncture and spinal manipulations	50% coinsurance for acupuncture and spinal manipulations	50% coinsurance for acupuncture and spinal manipulations	**Deductible** waived for acupuncture and spinal manipulations for **preferred providers**.
	Preventive care/ screening/immunization	No charge	No charge	No charge	none
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	50% coinsurance	**Deductible** waived for outpatient diagnostic test (x-ray, blood work) and imaging (CT/PET scans, MRIs) for **preferred providers**.
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	50% coinsurance	

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.RegenceRx.com.	Generic drugs	$10 copay / retail prescription $20 copay / mail order prescription No charge for self-administrable cancer chemotherapy drugs			Coverage is limited to a 30-day supply retail or 90-day supply mail order.
	Preferred brand drugs	$20 copay / retail prescription $40 copay / mail order prescription No charge for self-administrable cancer chemotherapy drugs			
	Non-preferred brand drugs	$30 copay / retail prescription $60 copay / mail order prescription No charge for self-administrable cancer chemotherapy drugs			
	Specialty drugs	Refer to generic, preferred brand and non-preferred brand drugs above.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	50% coinsurance	50% coinsurance	none
	Physician/surgeon fees	15% coinsurance	50% coinsurance	50% coinsurance	none
If you need immediate medical attention	Emergency room services	15% coinsurance after $100 copay	15% coinsurance after $100 copay	15% coinsurance after $100 copay	**Copayment** applies to the facility charge for each visit (waived if admitted), whether or not the **deductible** has been met.
	Emergency medical transportation	15% coinsurance	15% coinsurance	15% coinsurance	none
	Urgent care	Covered the same as the **If you visit a health care provider's office or clinic** or **If you have a test** Common Medical Events.			none
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	50% coinsurance	50% coinsurance	none
	Physician/surgeon fee	15% coinsurance	50% coinsurance	50% 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
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance	15% coinsurance	50% coinsurance	**Deductible** waived for outpatient services for **preferred** and participating **providers**.
	Mental/Behavioral health inpatient services	15% coinsurance	15% coinsurance	50% coinsurance	
	Substance use disorder outpatient services	15% coinsurance	15% coinsurance	50% coinsurance	
	Substance use disorder inpatient services	15% coinsurance	15% coinsurance	50% coinsurance	
If you are pregnant	Prenatal and postnatal care	15% coinsurance	50% coinsurance	50% coinsurance	none
	Delivery and all inpatient services	15% coinsurance	50% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	50% coinsurance	50% coinsurance	none
	Rehabilitation services	15% coinsurance	50% coinsurance	50% coinsurance	**Deductible** waived for outpatient services for **preferred providers**.
	Habilitation services	15% coinsurance	50% coinsurance	50% coinsurance	Coverage for neurodevelopmental therapy is limited to services for members through age 6.
	Skilled nursing care	15% coinsurance	50% coinsurance	50% coinsurance	none
	Durable medical equipment	15% coinsurance	50% coinsurance	50% coinsurance	none
	Hospice service	15% coinsurance	50% coinsurance	50% coinsurance	none
If your child needs dental or eye care	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.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs except for nutritional counseling
- Vision hardware

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
- Hearing aids
- Infertility treatment (diagnosis and treatment only)
- 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) 367-2116. 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, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or 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) 367-2116 or visit www.myRegence.com. You may also contact your state insurance department at 1 (800) 562-6900 or www.insurance.wa.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (888) 367-2116.

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) 367-2116.

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** $6,030
- **Patient pays** $1,510

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	$300
Copays	$20
Coinsurance	$1,040
Limits or exclusions	$150
Total	**$1,510**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,940
- **Patient pays** $1,460

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	$300
Copays	$1,100
Coinsurance	$20
Limits or exclusions	$40
Total	**$1,460**

Questions and answers about the Coverage Examples:

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