



2019/2020

Plan Description: REGENC-HSA 2700/80% -OR
Product: HDHP
Network: Preferred

Provider: Regence BCBS of Oregon
Member Services Phone #: 1-877-508-7357
Plan Website Address: <http://www.regence.com>

Benefit	In-Network	Out-of-Network
General Plan Information Lifetime Maximum Calendar Year Deductible - Individual Calendar Year Deductible - Family Carrier Coinsurance Member Coinsurance Calendar Year Out-of-Pocket Max - Individual Calendar Year Out-of-Pocket Max - Family	<ul style="list-style-type: none"> • Unlimited • \$2,700 • \$5,400 • 80% • 20% • \$6,000 • \$12,000 	<ul style="list-style-type: none"> • Unlimited • \$2,700 • \$5,400 • 60% • 40% • \$6,000 • \$12,000
Office Visits Primary Care Physician Visit Virtual Visit Specialist Visit Specialist Referral Required	<ul style="list-style-type: none"> • Deductible then 20% • Ded then 10% • Deductible then 20% • No 	<ul style="list-style-type: none"> • Deductible then 40% • Not Covered • Deductible then 40% • No
Hospital Care Hospital Care - Inpatient Hospital Care - Outpatient	<ul style="list-style-type: none"> • Deductible then 20% • Deductible then 20% 	<ul style="list-style-type: none"> • Deductible then 40% • Deductible then 40%
Emergency Care Emergency Room (In-Area) Urgent Care Facility	<ul style="list-style-type: none"> • Deductible then 20% • Deductible then 20% 	<ul style="list-style-type: none"> • Deductible then 20% • Deductible then 40%
Prescription Tier 1 Retail Tier 2 Retail Tier 3 Retail Tier 4 Retail Mail Order Medicare Part D Compatible	<ul style="list-style-type: none"> • Deductible then 20% • Deductible then 20% • Deductible then 20% • Not applicable • Deductible then 20% • Yes 	<ul style="list-style-type: none"> • Deductible then 20% • Deductible then 20% • Deductible then 20% • Not applicable • 20% after deductible • Yes
Maternity Care Pregnancy and Maternity Care (Pre-Natal Care)	<ul style="list-style-type: none"> • Deductible then 20% 	<ul style="list-style-type: none"> • Deductible then 40%
Preventive Care Preventive Services	<ul style="list-style-type: none"> • No Charge 	<ul style="list-style-type: none"> • 40% Coinsurance; deductible waived
Other Services Diagnostic X-Ray, Scans & Lab Chiropractic Care	<ul style="list-style-type: none"> • Deductible then 20% • Deductible then 20% 	<ul style="list-style-type: none"> • Deductible then 40% • Deductible then 40%

This benefit summary has been prepared by a licensed Insurance carrier or broker based on documents provided by the applicable licensed Insurance carrier. Please refer to the Plan Document and Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document or COC, the Plan Document and COC govern. This health insurance plan is part of a large group health plan, as such Medicare is the secondary payer for any insured member that is enrolled in Medicare and this plan. If eligible for Medicare due to ESRD, Medicare becomes primary payer after thirty months of Medicare eligibility. If member is a COBRA participant, Medicare is the primary payer.