Self-Managed and Consumer Directed Products

Self-Managed Product Introduction

Innova® and Engage® and Activate℠ products offer members choices about physicians, other health care professionals and facilities (hereafter referred to as providers); benefit levels and services. These products provide members with information and tools to help them manage their health care decisions. We refer to these products as self-managed plans. They do not require referrals or primary care physicians.

Innova

Innova is ideal for individuals and families that may seek medical care several times a year. Innova includes:

- Specific member benefits not subject to a deductible; as well as benefits that include copayments, deductibles and coinsurance
- Differing benefit levels based on the member's choice of provider

Engage

Engage offers simplicity to our members. Engage includes:
- Member benefits that are subject to a deductible
- A single benefit level for all providers

Activate

Activate rewards members for healthy behaviors, enabling their lifestyle choices to directly impact their health care options. Activate includes:

- Member benefits that are subject to a deductible
- Members earn reward points for a wide variety of health and wellness activities which they can use toward their deductible and coinsurance

This section is a summary of Innova, Engage and Activate products, including information about our built-in pharmacy benefits and wellness programs. Also included is information about our additional benefit options available to employer groups through medical plan participation, including, dental, spinal manipulations (with no benefit maximum) and vision.

More information about these products is available in the Products section of our *Provider Web Site* at **www.wa.regence.com/provider**.

Locating providers

Innova, Engage and Activate use well-established provider networks (Participating and Preferred) as well as non-contracted providers. Members can choose to seek services from any provider.

Participating and Preferred network providers can be found using our online directories available on our *Provider Web Site* or in our paper directories.

Benefit levels for each provider network differ between Innova, Engage and Activate. Additional benefit details are included in the following pages. For complete and current benefit information, use Provider Center, found on our *Provider Web Site* or contact Regence Provider Customer Service at 1 (800) 253-0838.

Innova

This section summarizes the provider networks and covered benefits for Innova.

Innova provider networks

Innova features provider choice; members have direct access to their choice of providers. A member's benefit level is determined by his or her choice of provider and the services received.

Innova defines the member's choice of benefit levels based on *categories of benefit choices*. For example, when a member seeks services from a Preferred network provider, the Category 1 choice (highest benefit level) applies and the member incurs the lowest out-of-pocket cost.

Provider networks	Categories of benefit choices	Benefit levels	Out-of-pocket costs
Preferred	Category 1	Highest	$
Participating	Category 2	Medium	$$
Non-contracted	Category 3	Lowest	$$$

Preferred network providers:

- Members who seek services from Preferred network providers generally incur the lowest out-of-pocket costs.
- Preferred network providers will not charge members for balances beyond any deductible, copayment and/or coinsurance amount for covered services.

Participating network providers:

- Members who seek services from Participating network providers generally incur higher out-of-pocket costs than when they seek services from Preferred network providers.

- Participating network providers will not charge members for balances beyond any deductible, copayment and/or coinsurance amount for covered services.

Non-contracted providers:
- Members who seek services from non-contracted providers generally incur the highest out-of-pocket costs.
- Non-contracted providers may bill members for balances over our allowable, in addition to any deductible, copayment and/or coinsurance amount for covered services.

BlueCard® Program

Innova members have access to contracted Blue Cross and/or Blue Shield (Blue Plan) providers across the country and world-wide through the BlueCard® Program.

Innova members have:
- Preferred provider organization (PPO) level of benefits when they obtain services from a provider designated as a BlueCard PPO provider.
- Participating benefit levels when they obtain services from a provider designated as a participating BlueCard provider.

More information about this program can be found in the *BlueCard* section of this manual.

Note: If you practice in several locations, your provider network may differ by location, depending on the agreement you signed with Regence BlueShield. For example, you may be a Preferred network provider in one location and a Participating network provider in another location. Your patients' out-of-pocket costs are based on their choice of provider. Therefore, you may want to encourage your patients to seek services from you at the location where they will receive the best benefit.

Innova benefits

Innova includes two types of benefits:
- Upfront benefits
- Member cost sharing

Upfront benefits

Innova members have coverage for office visits, including preventive exams and urgent care visits, outpatient radiology and laboratory services. Their deductible is waived for these upfront services and coinsurance does not apply.

Upfront office visits
The first four, six or unlimited office visits per calendar year (depending on the product option selected by the employer group) are not subject to the deductible or coinsurance (for Preferred and Participating providers only).

Individual copayment options for upfront office visits differ depending on the product option selected by the employer group and the member's choice of provider. Copayment options range from:

- $20 to $30 for Preferred providers
- $35 to $45 for Participating providers

The office visit copayment only applies to upfront office visits. There are no upfront office visit benefits for non-contracted providers. Office visits to non-contracted providers are subject to deductible and coinsurance.

Upfront outpatient radiology and laboratory

The first $400 of outpatient radiology and laboratory services from professional, independent laboratory or facility (excluding inpatient services) per calendar year is covered at 100% of the allowed amount and not subject to the deductible or coinsurance.

Expanded Office Services optional benefit

When this optional benefit is purchased, the following services (including related supplies) performed in the provider's office are subject to coinsurance only. The deductible and the office visit copayment do not apply:

- Anesthesia
- Office surgeries
- General medicine
- Therapeutic injections

Examples of services covered by this benefit include:
- Acne surgery
- Allergy shots
- Cast supplies such as plaster or fiberglass
- Incision and drainage of abscess
- Moderate sedation services
- Therapeutic injections of covered medications
- Wound repair

The following services are considered to be covered under their own specific benefit, even when performed in a doctor's office setting, and are **not** covered by the expanded office services benefit:

- Allergy testing (covered under Diagnostic Procedures benefit)
- Amniocentesis, diagnostic (covered under Maternity benefit)
- Arteriovenous (AV) shunt for dialysis (covered under Dialysis benefit)
- Cardiovascular stress test (covered under Diagnostic Procedures benefit)
- Diabetic education (covered under Diabetes Education benefit)
- Diaphragm or cervical cap fitting (covered under Family Planning benefit)
- Electrocardiogram (covered under Diagnostic Procedures benefit)
- Infusion therapy (covered under Infusion Therapy benefit) Immunizations, adult or child (covered under Immunization benefit)
- Laparoscopic treatment of ectopic pregnancy (covered under Maternity benefit)
- Orthognathic surgery (covered under the Orthognathic benefit)
- Physical therapy services (covered under Rehabilitation benefit)
- Vasectomy (covered under Family Planning benefit)

Member cost sharing

Members are responsible for deductibles and coinsurance amounts once they:
- Exhaust their upfront benefits or
- Receive a service that is not classified as an upfront benefit

For example, after members exhaust their upfront office visit benefit, any additional office visits do not require a copayment. However, members will be responsible for their deductible and coinsurance. After their deductible is met, coinsurance applies until the maximum coinsurance is met.

Calendar year deductible

If a member exhausts his or her upfront benefits or receives services not covered by upfront benefits, he or she must meet their individual or family deductible before care is reimbursed. The calendar year deductible applies to all covered expenses except where noted.

Calendar year deductible amounts:
- Individual deductible options per calendar year range from $250 to $5,000, depending on the product option selected by the employer group.
- The family deductible is three times the individual amount.

Each member's individual contribution to the family deductible cannot exceed the individual deductible amount. It is possible for a family to reach the family deductible before the individual deductibles are met. An example of a family with four members who have met their family deductible is shown below. Each family

member has a $250 individual deductible. None of the family members has met the individual deductible amount. However, the family has met its $750 family deductible.

Family Member	Amount of $250 individual deductible met
A	$200
B	$200
C	$200
D	$150
Total	**$750: Family deductible met**

Coinsurance options and coinsurance calendar year maximums

Once the deductible is met, members are responsible for coinsurance amounts.

Individual coinsurance options differ depending on the product option selected by the employer group and the member's choice of provider. Below are the three different options:

- 90% Preferred and 70% (Participating and non-contracted)
- 80% Preferred and 60% (Participating and non-contracted)
- 70% Preferred and 50% (Participating and non-contracted)

Coinsurance maximum amounts:

- Individual coinsurance maximum options per calendar year range from $2,000 to $6,000, depending on the product option selected by the employer group.
- The family coinsurance maximum is three times the individual amount.

Each member's individual contribution to the family coinsurance maximum cannot exceed the individual coinsurance maximum amount. It is possible for the family coinsurance maximum to be met before the individual maximum coinsurance amounts are met. An example of a family with four members who have met their family coinsurance maximum is shown below. Each family member has a $2,000 individual maximum coinsurance. None of the family members has met the individual maximum coinsurance amount. However, the family has met its $6,000 family maximum coinsurance.

Family Member	Amount of $2,000 individual maximum coinsurance met
A	$1,500
B	$1,500
C	$1,500
D	$1,500
Total	**$6,000: Family maximum coinsurance met**

Deductibles, copayments and provider balance billing do not accumulate toward the coinsurance maximum. The following exceptions apply:

- Upfront benefits not utilized prior to reaching the coinsurance maximum are still subject to copayment amounts.
- After the coinsurance maximums are met, covered services are paid at 100% of the allowed amount up to a $2,000,000 lifetime maximum.

Other benefits

- Childhood immunizations: Covered at 100% of the allowed amount and are not subject to deductible or coinsurance.
- Emergency room services: Features a $100 copayment, after which the member's deductible and coinsurance applies. The copayment will be waived if the member is admitted as an inpatient. ER services will be processed at the member's Category 1 benefit level (Preferred) for all providers.
- ER services (including all professional services such as MRI, CT scan, X-ray, laboratory and diagnostic procedures), billed on a *CMS-1500* form must include the place of service code (23 for ER) in block 24B.

Engage

This overview will explain the provider networks and covered benefits for Engage.

Engage provider networks

A single coinsurance level applies to Preferred, Participating and non-contracted providers.

Preferred and Participating network providers:

Providers will not charge members for balances beyond any deductible, copayment and/or coinsurance for covered services.

Non-contracted:

Providers may bill members for balances over our allowable in addition to any deductible, copayment and/or coinsurance amount for covered services.

BlueCard Program:

Engage members have participating benefit levels when they obtain services from providers designated as participating or preferred BlueCard providers.

Engage benefits

Engage offers simplicity to our members. Engage members have direct access to their choice of providers with a single coinsurance level that applies to Participating, Preferred and non-contracted providers. There are no upfront benefits.

Member cost sharing
All benefits are subject to deductible and coinsurance.

Calendar year deductible

Calendar year deductible amounts:

- Individual deductible options per calendar year range from $0 to $5,000, depending on the product option selected by the employer group.
- The family deductible is three times the individual amount.

The family deductible for Engage members works the same as it does for Innova members.

Coinsurance options and coinsurance calendar year maximums

Once the deductible is met, members are responsible for coinsurance amounts. Individual coinsurance options differ depending on the product option selected by the employer group and can be 80%, 70% or 50%.

Coinsurance maximum amounts:

- Individual coinsurance maximum options per calendar year range from $2,000 to $6,000, depending on the product option selected by the employer group.
- The family coinsurance maximum is three times the individual amount.

The family coinsurance for Engage members works the same as it does for Innova members.

After the coinsurance maximums are met, covered services are paid at 100% of the allowed amount up to a $2,000,000 lifetime maximum.

Deductibles, copayments and provider balance billing do not accumulate toward the coinsurance maximum.

Other benefits

- Childhood immunizations**:** Covered at 100% of the allowed amount and are not subject to deductible or coinsurance.
- Emergency room services: Features a $100 copayment, after which the

member's deductible and coinsurance applies. The copayment will be waived if the member is admitted as an inpatient.
- ER services (including all professional services such as MRI, CT scan, X-ray, laboratory and diagnostic procedures) billed on a *CMS-1500* form must include the place of service code (23 for ER) in block 24B.

Activate

This overview will explain the provider networks and covered benefits for Activate.

Activate provider networks

Like Innova and Engage, Activate features provider choice. Similar to Innova, an Activate member's benefit level is determined by his or her choice of provider and the services received. See the Innova section for more provider network information.

Activate benefits

Activate members have direct access to their choice of providers with two coinsurance levels; one for Preferred providers and the other for Participating and non-contracted providers. There are no copayments or upfront benefits.

Member cost sharing
All benefits are subject to deductible and coinsurance.

Calendar year deductible
Calendar year deductible amounts:
- Individual deductible options per calendar year range from $1,500 to $3,000, depending on the product option selected by the employer group.
- The family deductible is three times the individual amount.

The family deductible for Activate members works the same as it does for Innova and Engage members.

Coinsurance option and coinsurance calendar year maximums

Once the deductible is met, members are responsible for coinsurance amounts.

There is one individual coinsurance option,
- 80% Preferred and
- 60% Participating and non-contracted

Coinsurance maximum amounts:

- Individual coinsurance maximum options per calendar year range from $3,000 to $6,000, depending on the product option selected by the employer group.
- The family coinsurance maximum is three times the individual amount.

The family coinsurance for Activate members works the same as it does for Innova and Engage members. After the coinsurance maximums are met, covered services are paid at 100% of the allowed amount up to a $2,000,000 lifetime maximum. Deductibles and provider balance billing do not accumulate toward the coinsurance maximum.

Other benefits

- Adult and Childhood immunizations: Covered at 80% of the allowed amount after the deductible is met.
- Ambulance services: Covered at 80% of the allowed amount after the deductible is met.
- Emergency Room services (including all professional services such as MRI, CT scan, X-ray, laboratory and diagnostic procedures) billed on a *CMS-1500* form must include the place of service code (23 for ER) in block 24B.

Activate members who participate in and record Qualified Wellness Activities on **myRegence.com** earn reward points which are converted into Member Choice Funds. These funds can be used to pay for qualified, out-of-pocket medical expenses including deductibles and coinsurance amounts. When a member uses the funds in his or her Member Choice Account (MCA) to pay for an eligible medical claim, the payment will be made by Regence and listed as a separate item on the *Claim Voucher*. A sample Activate MCA payment is available in the *Payment* section of this manual.

Innova, Engage and Activate built-in and optional benefits and wellness programs

The following additional benefit options are available to employers who have purchase an Innova, Engage or Activate product. Optional benefits are offered at the employer group level; therefore, all members of an employer group with optional benefits, regardless of where they reside, are eligible for the optional benefits.

Pharmacy

Innova and Engage include pharmacy benefits. The pharmacy benefit offers a choice of tiered plan designs with three copayment, deductible and cost-share options. Members may be balance billed if a nonparticipating pharmacy is used.

Individual prescription medication copayment options differ depending on the product option selected by the employer group and range from:

- $5 to $10 for generics
- $25 to 35% for brand-name formulary and
- $50 to 50% for brand-name non-formulary

The employer group has a choice of brand-name calendar year deductibles ($0, $250 or $500) for prescription medications. The brand-name deductible is not applied to the prescription medication cost-share maximum. Generics are not subject to deductible. Individual prescription medication cost-share maximum options per calendar year differ depending on the product option selected by the employer group and can be $3,000, $4,000 or $5,000.

Activate also includes pharmacy benefits. The pharmacy benefit offers a choice of tiered plan designs with four copayment, deductible and cost-share options. Members may be balance billed if a nonparticipating pharmacy is used. Individual prescription medication copayment options differ depending on the product option selected by the employer group and range from:

- $5 to $10 or 10% for generics
- $35 to 30% for brand-name formulary and
- $75 to 50% for brand-name non-formulary

The employer group has a choice of brand-name calendar year deductibles ($250, $500 or $1,000) for prescription medications. The brand-name deductible is not applied to the prescription medication cost-share maximum. Generics are not subject to deductible.

Note: Diabetic supplies (test strips, lancets and blood glucose monitors) are covered under the pharmacy benefit and can be purchased through retail pharmacies.

Self-administered injectable drugs are covered under the pharmacy benefit and must be purchased through a retail pharmacy. *Exception*: The first three teaching doses per medication per lifetime can be covered under the medical benefit. The medication policy on self-administered injectable drugs is located at **http://blue.regence.com/trgmedpol/drugs/dru110.pdf**.

Innova, Engage and Activate feature RegenceRx, RegenceRx Web site; **myRegence.com**, powered by the Regence Engine and the *Regence Preferred Medication List*/Formulary. More information about RegenceRx can be found in the *RegenceRx Provider Basics* section of this manual.

Spinal Manipulations

These products include 10 spinal manipulations per calendar year, subject to deductible and coinsurance amounts. Individual coinsurance amounts for the optional rider differ depending on the product option selected by the employer group. An optional benefit with no benefit maximum is also available for purchase by the employer group. Individual coinsurance amounts for the optional rider differ depending on the product option selected.

Dental

Two dental plans are available for employer groups to purchase for their employees with Innova, Engage and Activate coverage: Encore and Expressions. Participating dentists and dental professionals are listed in our provider directory on our *Provider Web Site*.

The plans cover preventive services (cleanings, oral exams and x-rays), restorative services (fillings, oral surgery, endodontics and other similar procedures) and major services (crowns, bridges, onlays, dentures and endosteal implants). Individual dental deductible options per calendar year are either $25 or $50. Individual dental coinsurance maximum options per calendar year are $750, $1,000 or $1,500.

Vision

If purchased by the employer group, members can receive one eye exam per year and up to $150 of hardware (includes lenses, frames or contacts) annually. Both the exam and hardware are covered at 100% and are not subject to copayment or deductible amounts. Once the limit is reached, no additional benefit is available.

Wellness Programs

These products offer a full spectrum of programs that focus on health promotion activities. These programs support members in each stage of their health care needs, from preventive health and wellness to complex case management. More information is available in the *Care Management* section of this manual.

Regence HSA Healthplan 2.0℠ Product

Consumer Directed Product Introduction

Regence Health Savings Account (HSA) Healthplan 2.0℠ is a comprehensive, consumer directed health plan with the option for members to enroll in a tax-free savings account. It includes personalized wellness programs that encourage and reward the member for reaching their health goals; and enhanced support and interactive tools that make the plan easy to understand and use.

The following deductible options are available:

- Individual: $1,500, $2,500, $3,500, $5,000
- Family: $3,000, $5,000, $7,000, $10,00

Note: The $5,000 and $7,000 family deductible options are available with an optional $3,000 member deductible within the larger family deductible. When a family member satisfies the $3,000 deductible, benefits are paid for his or her covered services even if the family deductible is not satisfied. Once the family deductible is met, benefits are paid for covered services for all enrolled family members. If this option is not purchased, the family must reach the family deductible before any benefits are paid for covered services.

Networks

HSA Healthplan 2.0 utilizes existing Preferred (Category 1) and Participating (Category 2) provider networks, as well as non-contracted providers (Category 3). Members may choose to seek services from any provider. Benefit levels vary between each category.

Preferred and Participating network providers can be found using our online directories available on our *Provider Web Site*.

BlueCard Program

HSA Healthplan 2.0 members have access to contracted Blue Cross and/or Blue Shield (Blue Plan) providers across the country and world-wide through the BlueCard Program.

Banking

HSAs can be funded by employers, employees or even friends or family members of the employee. Regardless of who funds the account, the combined contributions cannot exceed the annual contribution limit as defined by the U.S. Treasury and the Internal Revenue Service (IRS).

Funds deposited in an HSA account may be used for qualified medical expenses (e.g., deductibles, coinsurance, medications) and are not taxable. The list of qualified medical expenses expands at age 65. However, if funds are used for a non-qualified expense, the money is taxable. The monies in this type of account are not lost if they are not used during a specific period of time; balances do roll over.

Many banking institutions will provide a debit card for the HSA account; increasing the ease and flexibility of HSAs. Regence currently has three banking options for establishing an HSA financial relationship.

Additional information for Self-Managed and Consumer Directed Products

Pre-authorization

Pre-authorization is required for some services. Physicians, other health care professionals and facilities are responsible for pre-authorizing all services listed on the *Medical Pre-authorization List*. The most current *Group and Individual Products Pre-authorization List* is included in the Care Management section of our *Provider Web Site*.

Coordination of benefits (COB)

Innova, Engage, Activate and HSA Healthplan 2.0 contain a coordination of benefits (COB) provision, ensuring that the total amount paid by all health plans does not exceed the actual cost of treatment. Coordination of benefits is vital in keeping the cost of coverage as low as possible.

Regence Customer Service

Regence has toll-free Customer Service phone numbers for you and separate Customer Service phone numbers for our Innova, Engage, Activate and HSA Healthplan 2.0 members. These phone numbers are different than the phone numbers for our other members.

Provider Customer Service
Contact Regence Provider Customer Service for inquiries regarding your Innova, Engage, Activate and HSA Healthplan 2.0 patients.

Member Customer Service
Innova, Engage, Activate and HSA Healthplan 2.0 members can contact our Member Customer Service phone number listed on the back of their member cards.

Regence Provider and Member Customer Service phone numbers for each of our products are included below:

REGENCE CUSTOMER SERVICE FOR INNOVA, ENGAGE, ACTIVATE AND HSA HEALTHPLAN 2.0		
Regence Plan	**Provider Customer Service Phone Numbers**	**Member Customer Service Phone Numbers**
Regence BlueShield of Idaho	Innova, Engage, Activate 1 (800) 475-1149 HSA Healthplan 2.0 1 (888) 849-0460	Innova and Engage: 1 (888) 367-2117 Activate: 1 (866) 219-6356 HSA Healthplan 2.0 1 (877) 508-7359
Regence BlueCross BlueShield of Oregon	Innova, Engage, Activate 1 (800) 452-6333 HSA Healthplan 2.0 1 (888) 849-0422	Innova and Engage: 1 (888) 367-2116 Activate: 1 (866) 219-2429 HSA Healthplan 2.0 1 (877) 508-7357
Regence BlueCross BlueShield of Utah	Innova, Engage, Activate 1 (877) 417-6222 HSA Healthplan 2.0 1 (888) 849-0447	Innova and Engage: 1 (888) 367-2119 Activate: 1 (866) 219-4426 HSA Healthplan 2.0 1 (877) 508-7360
Regence BlueShield (in Washington)	Innova, Engage, Activate 1 (800) 253-0838 HSA Healthplan 2.0 1 (888) 849-0299	Innova and Engage: 1 (888) 367-2112 Activate: 1 (866) 219-4116 HSA Healthplan 2.0 1 (877) 508-7358