Health plan overview:
What you pay

Regence BlueShield: 2023 Regence Employee Choice℠ plans—Preferred Network

Regence

All plans include Regence Advantages and discounts

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Platinum 250	Platinum 500	Platinum 850
In-network deductible / out-of-network deductible	**$250** / $3,000	**$500** / $3,000	**$850** / $3,000
In-network OOPM / out-of-network OOPM	**$4,000** / $10,000	**$4,000** / $10,000	**$850** / $10,000
Preventive care	**Covered in full for in-network services**		
Employee Assistance Program (4 counseling visits per incident)	**Covered in full**		
Behavioral health	**$20**	**$20**	**0%**
Virtual care	**$10**	**$10**	**0%**
Primary care provider	**$20**	**$20**	**0%**
Specialist	**$30**	**$30**	**0%**
Urgent care	**$30**	**$30**	**0%**
Maternity	**10%**	**10%**	**0%**
Inpatient hospital	**10%**	**10%**	**0%**
Outpatient surgery and services	**10%**	**10%**	**0%**
Outpatient lab and radiology	**0%**	**0%**	**0%**
Outpatient complex lab and imaging	**10%**	**10%**	**0%**
Outpatient rehab	**$20**	**$20**	**0%**
Emergency room	**$250 plus 10% coinsurance**	**$250 plus 10% coinsurance**	**0%**
Hearing aids and evaluation $1,000 limit per calendar year, regardless of age	**10%**	**10%**	**0%**
Pediatric vision up to age 19	**Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year**		
Pediatric dental up to age 19	**0% Preventive, 20% Basic, 50% Major**		
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	**$20**	**$20**	**0%**
In-network coinsurance for other covered medical care	**10%**	**10%**	**0%**
Out-of-network coinsurance for covered medical care	50%	50%	50%
Optimum Value Medication List	N/A	N/A	**Yes**
Rx Preferred generic	**$8**	**$8**	**$0**
Rx Generic	**$30**	**$35**	**$0**
Rx Preferred brand*	**$30**	**$30**	**$0**
Rx Preferred specialty*	**20%**	**20%**	**$0**

= Deductible waived = Deductible applies

*Non-preferred Rx brand and specialty may be available at a higher cost-share

Health plan overview:
What you pay

Regence BlueShield: 2023 Regence Employee Choice℠ plans—Preferred Network

Regence

All plans include Regence Advantages and discounts

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Gold 500	Gold 1000	Gold 1500	Gold 2000	Gold 2500
In-network deductible / out-of-network deductible	**$500** / $5,000	**$1,000** / $5,000	**$1,500** / $5,000	**$2,000** / $5,000	**$2,500** / $5,000
In-network OOPM / out-of-network OOPM	**$7,500** / $10,000	**$7,000** / $10,000	**$8,550** / $10,000	**$5,750** / $10,000	**$7,350** / $10,000
Preventive care	**Covered in full for in-network services**				
Employee Assistance Program (4 counseling visits per incident)	**Covered in full**				
Behavioral health	**$30**	**$30**	**$30**	**$30**	**$30**
Virtual care	**$10**	**$10**	**$10**	**$10**	**$10**
Primary care provider	**$30**	**$30**	**$30**	**$30**	**$30**
Specialist	**$50**	**$50**	**$50**	**$50**	**$50**
Urgent care	**$50**	**$50**	**$50**	**$50**	**$50**
Maternity	**30%**	**30%**	**20%**	**25%**	**30%**
Inpatient hospital	**30%**	**30%**	**20%**	**25%**	**30%**
Outpatient surgery and services	**30%**	**30%**	**20%**	**25%**	**30%**
Outpatient lab and radiology	30%	30%	20%	25%	30%
Outpatient complex lab and imaging	**30%**	**30%**	**20%**	**25%**	**30%**
Outpatient rehab	$30	$30	$30	$30	$30
Emergency room	**$300 plus 30% coinsurance**	**$300 plus 30% coinsurance**	**$300 plus 20% coinsurance**	**$300 plus 25% coinsurance**	**$300 plus 30% coinsurance**
Hearing aids and evaluation $1,000 limit per calendar year, regardless of age	**30%**	**30%**	**20%**	**25%**	**30%**
Pediatric vision up to age 19	**Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year**				
Pediatric dental up to age 19	**0% Preventive, 20% Basic, 50% Major**				
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	**$30**	**$30**	**$30**	**$30**	**$30**
In-network coinsurance for other covered medical care	**30%**	**30%**	**20%**	**25%**	**30%**
Out-of-network coinsurance for covered medical care	50%	50%	50%	50%	50%
Optimum Value Medication List	N/A	N/A	N/A	N/A	N/A
Rx Preferred generic	**$10**	**$10**	**$15**	**$10**	**$10**
Rx Generic	**$35**	**$35**	**$35**	**$35**	**$35**
Rx Preferred brand*	**$50**	**$50**	**$50**	**$50**	**$50**
Rx Preferred specialty*	**20%**	**20%**	**20%**	**20%**	**20%**

= Deductible waived = Deductible applies *Non-preferred Rx brand and specialty may be available at a higher cost-share

Health plan overview:
What you pay

Regence BlueShield: 2023 Regence Employee Choice℠ plans—Preferred Network

Regence

All plans include Regence Advantages and discounts

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Silver 3000	Silver 5500	Bronze 8550
In-network deductible / out-of-network deductible	**$3,000** / $5,000	**$5,500** / $7,500	**$8,550** / $10,000
In-network OOPM / out-of-network OOPM	**$8,550** / $10,000	**$7,500** / $10,000	**$8,550** / $15,000
Preventive care	**Covered in full for in-network services**		
Employee Assistance Program (4 counseling visits per incident)	**Covered in full**		
Behavioral health	**$40**	**$40**	**0%**
Virtual care	**$10**	**$10**	**0%**
Primary care provider	**$40**	**$40**	**0%**
Specialist	**$60**	**$60**	**0%**
Urgent care	**$60**	**$60**	**0%**
Maternity	**35%**	**50%**	**0%**
Inpatient hospital	**35%**	**50%**	**0%**
Outpatient surgery and services	**35%**	**50%**	**0%**
Outpatient lab and radiology	**35%**	**50%**	**0%**
Outpatient complex lab and imaging	**35%**	**50%**	**0%**
Outpatient rehab	**$40**	**$40**	**0%**
Emergency room	**$400 plus 35% coinsurance**	**$400 plus 50% coinsurance**	**0%**
Hearing aids and evaluation $1,000 limit per calendar year, regardless of age	**35%**	**50%**	**0%**
Pediatric vision up to age 19	**Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year**		
Pediatric dental up to age 19	**0% Preventive, 20% Basic, 50% Major**		
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	**$40**	**$40**	**0%**
In-network coinsurance for other covered medical care	**35%**	**50%**	**0%**
Out-of-network coinsurance for covered medical care	50%	50%	50%
Optimum Value Medication List	N/A	N/A	**Yes**
Rx Preferred generic	**$20**	**$20**	**0%**
Rx Generic	**$35**	**$35**	**0%**
Rx Preferred brand*	**$60**	**$60**	**0%**
Rx Preferred specialty*	**20%**	**20%**	**0%**

= Deductible waived = Deductible applies

*Non-preferred Rx brand and specialty may be available at a higher cost-share

Health plan overview:
What you pay

Regence BlueShield: 2023 Regence Employee Choice℠ plans—Preferred Network

Regence

All plans include Regence Advantages and discounts

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Gold HSA 1500	Silver HSA 2500	Silver HSA Embedded 3000	Silver HSA 3500	Silver HSA 4850	Bronze HSA 5500
In-network deductible / out-of-network deductible	**$1,500** / $5,000	**$2,500** / $5,000	**$3,000** / $5,000	**$3,500** / $5,000	**$4,850** / $5,000	**$5,500** / $10,000
In-network OOPM / out-of-network OOPM	**$4,500** / $10,000	**$6,900** / $10,000	**$6,000** / $10,000	**$6,900** / $10,000	**$4,850** / $10,000	**$7,000** / $15,000
Preventive care	**Covered in full for in-network services**					
Employee Assistance Program (4 counseling visits per incident)	**Covered in full**					
Behavioral health	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Virtual care	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Primary care provider	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Specialist	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Urgent care	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Maternity	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Inpatient hospital	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Outpatient surgery and services	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Outpatient lab and radiology	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Outpatient complex lab and imaging	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Outpatient rehab	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Emergency room	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Hearing aids and evaluation $1,000 limit per calendar year, regardless of age	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Pediatric vision up to age 19	**Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year**					
Pediatric dental up to age 19	**0% Preventive, 20% Basic, 50% Major**					
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
In-network coinsurance for other covered medical care	**20%**	**30%**	**25%**	**20%**	**0%**	**50%**
Out-of-network coinsurance for covered medical care	50%	50%	50%	50%	50%	50%
Optimum Value Medication List	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Rx Preferred generic	**10%**	**10%**	**10%**	**10%**	**0%**	**50%**
Rx Generic	**25%**	**25%**	**25%**	**25%**	**0%**	**50%**
Rx Preferred brand*	**25%**	**35%**	**35%**	**35%**	**0%**	**50%**
Rx Preferred specialty*	**20%**	**20%**	**20%**	**20%**	**0%**	**20%**

= Deductible waived = Deductible applies

*Non-preferred Rx brand and specialty may be available at a higher cost-share

Health plan overview:
What you pay

Regence BlueShield: 2023 Regence Employee Choice℠ plans—Preferred Network

Regence

All plans include Regence Advantages and discounts

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Silver Essential 2500	Silver Essential 4000	Bronze Essential 7500
In-network deductible / out-of-network deductible	**$2,500** / $5,000	**$4,000** / $5,000	**$7,500** / $10,000
In-network OOPM / out-of-network OOPM	**$8,150** / $10,000	**$8,150** / $10,000	**$8,550** / $15,000
Preventive care	**Covered in full for in-network services**		
Employee Assistance Program (4 counseling visits per incident)	**Covered in full**		
Behavioral health	**30%**	**20%**	**30%**
Virtual care	**Covered in full for in-network services**		
Primary care provider	**$40 upfront limited to 10 combined visits; deductible and coinsurance after visit limit is met**	**$40 upfront limited to 4 combined visits; deductible and coinsurance after visit limit is met**	**$40 upfront limited to 4 combined visits; deductible and coinsurance after visit limit is met**
Specialist			
Urgent care			
Maternity	**30%**	**20%**	**30%**
Inpatient hospital	**30%**	**20%**	**30%**
Outpatient surgery and services	**30%**	**20%**	**30%**
Outpatient lab and radiology	**30%**	**20%**	**30%**
Outpatient complex lab and imaging	**30%**	**20%**	**30%**
Outpatient rehab	**30%**	**20%**	**30%**
Emergency room	**30%**	**20%**	**30%**
Hearing aids and evaluation $1,000 limit per calendar year, regardless of age	**30%**	**20%**	**30%**
Pediatric vision up to age 19	**Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year**		
Pediatric dental up to age 19	**0% Preventive, 20% Basic, 50% Major**		
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	**30%**	**20%**	**30%**
In-network coinsurance for other covered medical care	**30%**	**20%**	**30%**
Out-of-network coinsurance for covered medical care	50%	50%	50%
Optimum Value Medication List	N/A	N/A	N/A
Rx Preferred generic	**$15**	**$10**	**$10**
Rx Generic	**$35**	**$35**	**$35**
Rx Preferred brand*	**25%**	**25%**	**25%**
Rx Preferred specialty*	**20%**	**20%**	**20%**

= Deductible waived = Deductible applies

*Non-preferred Rx brand and specialty may be available at a higher cost-share

Health plan overview:
What you pay

Regence BlueShield: 2023 Regence Employee Choice℠ plans—Eastside Health Network

Regence

All plans include Regence Advantages and discounts

These plans only cover care provided in the network. Out-of-network care is not covered (except for urgent, emergency, and approved out-of-network services)

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Platinum 500	Gold 1000	Silver 3500	Silver HSA 2500	Bronze HSA 5500	Silver Essential 4000	Bronze Essential 7500
In-network deductible	$500	$1,000	$3,500	$2,500	$5,500	$4,000	$7,500
In-network OOPM	$4,000	$7,000	$8,150	$6,900	$7,000	$8,150	$8,550
Preventive care	Covered in full			Covered in full		Covered in full	
Employee Assistance Program (4 counseling visits per incident)	Covered in full			Covered in full		Covered in full	
Behavioral health	$20	$30	$40	30%	50%	20%	30%
Virtual care	$10	$10	$10	30%	50%	Covered in full	
Primary care provider	$20	$30	$40	30%	50%	$40 upfront limited to 4 combined visits; deductible and coinsurance after visit limit is met	
Specialist	$30	$50	$60	30%	50%		
Urgent care	$30	$50	$60	30%	50%		
Maternity	10%	30%	35%	30%	50%	20%	30%
Inpatient hospital	10%	30%	35%	30%	50%	20%	30%
Outpatient surgery and services	10%	30%	35%	30%	50%	20%	30%
Outpatient lab and radiology	0%	30%	35%	30%	50%	20%	30%
Outpatient complex lab and imaging	10%	30%	35%	30%	50%	20%	30%
Outpatient rehab	$20	$30	$40	30%	50%	20%	30%
Emergency room	$250 plus 10% coinsurance	$300 plus 30% coinsurance	$400 plus 35% coinsurance	30%	50%	20%	30%
Hearing aids and evaluation $1,000 limit per calendar year, regardless of age	10%	30%	35%	30%	50%	20%	30%
Pediatric vision up to age 19	Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year			Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year		Annual eye exam plus one pair of frames and lenses, or one pair of contacts per year	
Pediatric dental up to age 19	0% Preventive, 20% Basic, 50% Major			0% Preventive, 20% Basic, 50% Major		0% Preventive, 20% Basic, 50% Major	
Acupuncture / spinal manipulations (12 / 10 annual visit limit)	$20	$30	$40	30%	50%	20%	30%
Coinsurance for other covered medical care	10%	30%	35%	30%	50%	20%	30%
Optimum Value Medication List	N/A	N/A	N/A	Yes	Yes	N/A	N/A
Rx Preferred generic	$8	$10	$20	10%	50%	$10	$10
Rx Generic	$35	$35	$35	25%	50%	$35	$35
Rx Preferred brand*	$30	$50	$60	35%	50%	25%	25%
Rx Preferred specialty*	20%	20%	20%	20%	20%	20%	20%

= Deductible waived = Deductible applies *Non-preferred Rx brand and specialty may be available at a higher cost-share

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield
1800 Ninth Avenue | Seattle, WA 98101

REG-WA-325464-22/10