What you pay

Regence BlueShield: 2024 Regence Employee Choice℠ plans

Regence

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Silver Essential 2500	Silver Essential 4000	Silver Essential 4000	Bronze Essential 7500	Bronze Essential 7500
Networks offered on these plans	Preferred	Preferred	Eastside Health Network	Preferred	Eastside Health Network
In-network deductible / out-of-network deductible	**$2,500** / $5,000	**$4,000** / $5,000	**$4,000** / Not covered	**$7,500** / $10,000	**$7,500** / Not covered
In-network OOPM / out-of-network OOPM	**$8,500** / $10,000	**$8,150** / $10,000	**$8,150** / Not covered	**$9,100** / $15,000	**$9,100** / Not covered
Preventive care	Covered in full for in-network services				
Regence Advantages	regence.com/member/resources/advantages-discounts **Program is offered in addition to your medical plan but is not insurance**				
Employee Assistance Program	Covered in full (4 counseling visits per incident)				
Behavioral health	**30%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
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	$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%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
Inpatient hospital	**30%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
Outpatient surgery & services	**30%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
Outpatient lab & radiology	**30%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
Outpatient complex lab & imaging	**30%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
Outpatient rehab	**30%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
Emergency room	**30%** / 30%	**20%** / 20%	**20%** / 20%	**30%** / 30%	**30%** / 30%
Hearing aids and evaluation $1,000 limit (device only) per calendar year, regardless of age	**30%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
Pediatric vision up to age 19	Annual eye exam plus 1 pair of frames and lenses, or 1 pair of contacts per year				
Pediatric dental up to age 19	0% Preventive, 20% Basic, 50% Major				
Acupuncture / spinal manipulation (12 / 10 visits per year)	**30%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
In-network coinsurance for other covered medical care / out-of-network coinsurance	**30%** / 50%	**20%** / 50%	**20%** / Not covered	**30%** / 50%	**30%** / Not covered
Optimum Value Medication List	N/A	N/A	N/A	N/A	N/A
Rx Tier 1 (Preferred generics)	$15	$10	$10	$10	$10
Rx Tier 2 (Generics)	$35	$35	$35	$35	$35
Rx Tier 3 (Preferred brands)	25%	25%	25%	25%	25%
Rx Tier 4 (Brands)	50%	50%	50%	50%	50%
Rx Tier 5 (Preferred specialty)	20%	20%	20%	20%	20%
Rx Tier 6 (Specialty)	50%	50%	50%	50%	50%

= Deductible waived = Deductible applies

What you pay

Regence BlueShield: 2024 Regence Employee Choice℠ plans

Regence

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Gold HSA 1600	Silver HSA 2700	Silver HSA 2700	Silver HSA Embedded 3200	Silver HSA 5150	Silver HSA 3500	Bronze HSA 6000	Bronze HSA 6000
Networks offered on these plans	Preferred	Preferred	Eastside Health Network	Preferred	Preferred	Preferred	Preferred	Eastside Health Network
In-network deductible / out-of-network deductible	**$1,600** / $5,000	**$2,700** / $5,000	**$2,700** / Not covered	**$3,200** / $5,000	**$5,150** / $7,500	**$3,500** / $5,000	**$6,000** / $10,000	**$6,000** / Not covered
In-network OOPM / out-of-network OOPM	**$4,500** / $10,000	**$6,900** / $10,000	**$6,900** / Not covered	**$6,700** / $10,000	**$5,150** / $15,000	**$6,900** / $10,000	**$7,150** / $15,000	**$7,150** / Not covered
Preventive care	Covered in full for in-network services							
Regence Advantages	regence.com/member/resources/advantages-discounts **Program is offered in addition to your medical plan but is not insurance**							
Employee Assistance Program	Covered in full (4 counseling visits per incident)							
Behavioral health	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Virtual care	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Primary care provider	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Specialist	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Urgent care	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Maternity	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Inpatient hospital	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Outpatient surgery & services	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Outpatient lab & radiology	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Outpatient complex lab & imaging	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Outpatient rehab	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Emergency room	**20%** / 20%	**30%** / 30%	**30%** / 30%	**25%** / 25%	**0%** / 0%	**20%** / 20%	**50%** / 50%	**50%** / 50%
Hearing aids and evaluation $1,000 limit (device only) per calendar year, regardless of age	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Pediatric vision up to age 19	Annual eye exam plus 1 pair of frames and lenses, or 1 pair of contacts per year							
Pediatric dental up to age 19	0% Preventive, 20% Basic, 50% Major							
Acupuncture / spinal manipulation (12 / 10 visits per year)	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
In-network coinsurance for other covered medical care / out-of-network coinsurance	**20%** / 50%	**30%** / 50%	**30%** / Not covered	**25%** / 50%	**0%** / 50%	**20%** / 50%	**50%** / 50%	**50%** / Not covered
Optimum Value Medication List	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rx Tier 1 (Preferred generics)	10%	10%	10%	10%	0%	10%	50%	50%
Rx Tier 2 (Generics)	25%	25%	25%	25%	0%	25%	50%	50%
Rx Tier 3 (Preferred brands)	25%	35%	35%	35%	0%	35%	50%	50%
Rx Tier 4 (Brands)	50%	50%	50%	50%	0%	50%	50%	50%
Rx Tier 5 (Preferred specialty)	20%	20%	20%	20%	0%	20%	20%	20%
Rx Tier 6 (Specialty)	50%	50%	50%	50%	0%	50%	50%	50%

= Deductible waived = Deductible applies

What you pay

Regence BlueShield: 2024 Regence Employee Choice℠ plans

Regence

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Platinum 250	Platinum 500	Platinum 500	Platinum 900	Gold 500	Gold 1000	Gold 1000	Gold 1500
Networks offered on these plans	Preferred	Preferred	Eastside Health Network	Preferred	Preferred	Preferred	Eastside Health Network	Preferred
In-network deductible / out-of-network deductible	**$250** / $3,000	**$500** / $3,000	**$500** / Not covered	**$900** / $3,000	**$500** / $5,000	**$1,000** / $5,000	**$1,000** / Not covered	**$1,500** / $5,000
In-network OOPM / out-of-network OOPM	**$4,000** / $10,000	**$4,000** / $10,000	**$4,000** / Not covered	**$900** / $10,000	**$7,500** / $10,000	**$7,000** / $10,000	**$7,000** / Not covered	**$8,550** / $10,000
Preventive care	Covered in full for in-network services							
Regence Advantages	regence.com/member/resources/advantages-discounts **Program is offered in addition to your medical plan but is not insurance**							
Employee Assistance Program	Covered in full (4 counseling visits per incident)							
Behavioral health	$20	$20	$20	**0%** / 50%	$30	$30	$30	$30
Virtual care	$10	$10	$10	**0%** / 50%	$10	$10	$10	$10
Primary care provider	$20	$20	$20	**0%** / 50%	$30	$30	$30	$30
Specialist	$30	$30	$30	**0%** / 50%	$50	$50	$50	$50
Urgent care	$30	$30	$30	**0%** / 50%	$50	$50	$50	$50
Maternity	**10%** / 50%	**10%** / 50%	**10%** / Not covered	**0%** / 50%	**30%** / 50%	**30%** / 50%	**30%** / Not covered	**20%** / 50%
Inpatient hospital	**10%** / 50%	**10%** / 50%	**10%** / Not covered	**0%** / 50%	**30%** / 50%	**30%** / 50%	**30%** / Not covered	**20%** / 50%
Outpatient surgery & services	**10%** / 50%	**10%** / 50%	**10%** / Not covered	**0%** / 50%	**30%** / 50%	**30%** / 50%	**30%** / Not covered	**20%** / 50%
Outpatient lab & radiology*	**0%** / 50%	**0%** / 50%	**0%** / Not covered	**0%** / 50%	**30%** / 50%	**30%** / 50%	**30%** / Not covered	**20%** / 50%
Outpatient complex lab & imaging	**10%** / 50%	**10%** / 50%	**10%** / Not covered	**0%** / 50%	**30%** / 50%	**30%** / 50%	**30%** / Not covered	**20%** / 50%
Outpatient rehab	$20	$20	$20	**0%** / 50%	$30	$30	$30	$30
Emergency room	$250 then coinsurance	$250 then coinsurance	$250 then coinsurance	**0%** / 0%	$300 then coinsurance	$300 then coinsurance	$300 then coinsurance	$300 then coinsurance
Hearing aids and evaluation $1,000 limit (device only) per calendar year, regardless of age	**10%** / 50%	**10%** / 50%	**10%** / Not covered	**0%** / 50%	**30%** / 50%	**30%** / 50%	**30%** / Not covered	**20%** / 50%
Pediatric vision up to age 19	Annual eye exam plus 1 pair of frames and lenses, or 1 pair of contacts per year							
Pediatric dental up to age 19	0% Preventive, 20% Basic, 50% Major							
Acupuncture / spinal manipulation (12 / 10 visits per year)	$20	$20	$20	**0%** / 50%	$30	$30	$30	$30
In-network coinsurance for other covered medical care / out-of-network coinsurance	**10%** / 50%	**10%** / 50%	**10%** / Not covered	**0%** / 50%	**30%** / 50%	**30%** / 50%	**30%** / Not covered	**20%** / 50%
Optimum Value Medication List	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
Rx Tier 1 (Preferred generics)	$8	$8	$8	$0	$10	$10	$10	$15
Rx Tier 2 (Generics)	$30	$35	$35	$0	$35	$35	$35	$35
Rx Tier 3 (Preferred brands)	$30	$30	$30	$0	$50	$50	$50	$50
Rx Tier 4 (Brands)	50%	50%	50%	$0	50%	50%	50%	50%
Rx Tier 5 (Preferred specialty)	20%	20%	20%	$0	20%	20%	20%	20%
Rx Tier 6 (Specialty)	50%	50%	50%	$0	50%	50%	50%	50%

= Deductible waived = Deductible applies

*The deductible is waived only for in-network care. Out-of-network care is subject to the out-of-network deductible.

What you pay

Regence BlueShield: 2024 Regence Employee Choice℠ plans

Regence

Family deductible and out-of-pocket maximum (OOPM) is 2x individual	Gold 2000	Gold 2500	Silver 3000	Silver 3000	Silver 5500	Bronze 8550
Networks offered on these plans	Preferred	Preferred	Preferred	Eastside Health Network	Preferred	Preferred
In-network deductible / out-of-network deductible	**$2,000** / $5,000	**$2,500** / $5,000	**$3,000** / $5,000	**$3,000** / Not covered	**$5,500** / $7,500	**$8,550** / $10,000
In-network OOPM / out-of-network OOPM	**$5,750** / $10,000	**$7,350** / $10,000	**$8,650** / $10,000	**$8,650** / Not covered	**$7,900** / $10,000	**$8,550** / $15,000
Preventive care	Covered in full for in-network services					
Regence Advantages	regence.com/member/resources/advantages-discounts **Program is offered in addition to your medical plan but is not insurance**					
Employee Assistance Program	Covered in full (4 counseling visits per incident)					
Behavioral health	$30	$30	$40	$40	$40	**0%** / 50%
Virtual care	$10	$10	$10	$10	$10	**0%** / 50%
Primary care provider	$30	$30	$40	$40	$40	**0%** / 50%
Specialist	$50	$50	$60	$60	$60	**0%** / 50%
Urgent care	$50	$50	$60	$60	$60	**0%** / 50%
Maternity	**25%** / 50%	**30%** / 50%	**35%** / 50%	**35%** / Not covered	**50%** / 50%	**0%** / 50%
Inpatient hospital	**25%** / 50%	**30%** / 50%	**35%** / 50%	**35%** / Not covered	**50%** / 50%	**0%** / 50%
Outpatient surgery & services	**25%** / 50%	**30%** / 50%	**35%** / 50%	**35%** / Not covered	**50%** / 50%	**0%** / 50%
Outpatient lab & radiology*	**25%** / 50%	**30%** / 50%	**35%** / 50%	**35%** / Not covered	**50%** / 50%	**0%** / 50%
Outpatient complex lab & imaging	**25%** / 50%	**30%** / 50%	**35%** / 50%	**35%** / Not covered	**50%** / 50%	**0%** / 50%
Outpatient rehab	$30	$30	$40	$40	$40	**0%** / 50%
Emergency room	$300 then coinsurance	$300 then coinsurance	$400 then coinsurance	$400 then coinsurance	$400 then coinsurance	0%
Hearing aids and evaluation $1,000 limit (device only) per calendar year, regardless of age	**25%** / 50%	**30%** / 50%	**35%** / 50%	**35%** / Not covered	**50%** / 50%	**0%** / 50%
Pediatric vision up to age 19	Annual eye exam plus 1 pair of frames and lenses, or 1 pair of contacts per year					
Pediatric dental up to age 19	0% Preventive, 20% Basic, 50% Major					
Acupuncture / spinal manipulation (12 / 10 visits per year)	$30	$30	$40	$40	$40	**0%** / 50%
In-network coinsurance for other covered medical care / out-of-network coinsurance	**25%** / 50%	**30%** / 50%	**35%** / 50%	**35%** / Not covered	**50%** / 50%	**0%** / 50%
Optimum Value Medication List	N/A	N/A	N/A	N/A	N/A	Yes
Rx Tier 1 (Preferred generics)	$10	$10	$20	$20	$20	0%
Rx Tier 2 (Generics)	$35	$35	$35	$35	$35	0%
Rx Tier 3 (Preferred brands)	$50	$50	$60	$60	$60	0%
Rx Tier 4 (Brands)	50%	50%	50%	50%	50%	0%
Rx Tier 5 (Preferred specialty)	20%	20%	20%	20%	20%	0%
Rx Tier 6 (Specialty)	50%	50%	50%	50%	50%	0%

= Deductible waived = Deductible applies

*The deductible is waived only for in-network care. Out-of-network care is subject to the out-of-network deductible.

Regence

Regence BlueShield
1800 Ninth Avenue | Seattle, WA 98101

REG-WA-1072326-23/10