WASHINGTON FLORAL SERVICE

Employee Benefit Summary
Effective December 1, 2020

FOR QUESTIONS OR CONCERNS REGARDING ELIGIBILITY, CLAIMS OR BENEFITS, PLEASE CONTACT:

Regence	Customer Service	888-367-2112
Regence	On-line Provider Directory	www.regence.com
Reliant Behaviorial Health	Employee Assistance Program	1-866-750-1327

	Regence Classic $4,000	**Regence Classic $2,000**
Provider Network	**Regence Preferred - In Network**	**Regence Preferred - In Network**
Calendar Year Deductible	$4,000 per Person / $12,000 per Family	$2,000 per Person / $6,000 per Family
Calendar Year Out of Pocket Maximum	$7,150 per Person / $14,300 per Family	$5,500 per Person / $11,000 per Family
Preventive Care		
Office Visit	Covered in full	Covered in full
Immunizations	Covered in full	Covered in full
Professional Care/Diagnostic Services		
Office Visit	*$30 copay Primary / $30 Specialists	*$30 copay Primary / $30 Specialists
Telehealth	*$10 Copay	*$10 Copay
Outpatient X-ray & Lab - Basic	30% after deductible	20% after deductible
Complex Imaging	30% after deductible	20% after deductible
Hospitalization		
Inpatient and Outpatient	30% after deductible	20% after deductible
Emergency Room	$100 copay, then 30% after deductible	$100 copay, then 20% after deductible
Other Benefits		
Ambulance	30% after deductible	20% after deductible
Chemical Dependency/Mental Health - Inpatient	30% after deductible	20% after deductible
Chemical Dependency/Mental Health - Outpatient	*$30 copay	*$30 copay
Chiropractic Care	$30 copay - 12 visits max per cal. year	$30 copay - 12 visits max per cal. year
Maternity	30% after deductible	20% after deductible
Prescription Drugs - 30 Day Supply	**Deductible waived for all tiers**	**Deductible waived for all tiers**
Generic Preferred / Non Preferred	*$10 copay / 25% coinsurance	*$10 copay / 25% coinsurance
Brand Preferred / Non Preferred	*$35 copay / $75 copay	*$35 copay / $75 copay
Specialty Preferred / Non Preferred	*$150 copay / 50% coinsurance	*$150 copay / 50% coinsurance
Out of Network		
Deductible	Incresed out of pocket deductible	Incresed out of pocket deductible
Out of Pocket Maximum	Increased out of pocket maximum	Increased out of pocket maximum
Co-Insurance	50%	40%
Employee Assistance Program (EAP)		
Up to 4 confidential counseling sessions for many issues	Free to you as an employee and anyone living in your household	Free to you as an employee and anyone living in your household
Dental	**Regence Contracting Dentist**	**Any Licensed Dentist (may balance bill)**
Annual Deductible	$50 per person, waived for Type A Services	$50 per person, waived for Type A Services
Annual Maximum	$1,000	$1,000
Type A - Preventive & Diagnostic Services	0%	0%
Type B - Basic Services	20%	20%
Type C - Major Services	50%	50%

*** Benefits Not Subject to the Annual Deductible**

PLEASE NOTE: This is a brief summary of benefits only and does *not* constitute a contract. You will be receiving a benefit booklet which completely outlines your benefits. Please consult your booklet for specific details, exclusions and limitations.