Regence IAFN Bronze Essential 8500 With 4 Copay No Deductible Office Visits POS

Individual and Family Network - Managed Care Plan

Regence BlueShield of Idaho, Inc.

Effective January 1, 2024 through December 31, 2024

Regence BlueShield of Idaho is an Independent Licensee of the BlueCross and BlueShield Association

Cost Share Details		In-Network	Out-of-Network
Annual Medical Deductible	The total deductible You pay per calendar year	$8,500 Individual $17,000 Family	$16,300 Individual $32,600 Family
Annual Prescription Deductible	The total deductible You pay per calendar year for prescription medications	Shared with medical	
Annual Out-of-Pocket Maximum	The combined total for Your deductible(s), coinsurance and copays per calendar year	$9,450 Individual $18,900 Family	$81,500 Individual $163,000 Family

10 Essential Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
1. Ambulatory Care	Primary Care Visits (for Illness or Injury)	$60 copay per visit, deductible waived for first 4 visits combined, then 10% coinsurance, deductible applies	60%
	Specialist Visits		60%
	Urgent Care Visits		Covered as In-Network
2. Emergency Care	Emergency Room Care	10%, In-Network deductible applies	
	Ambulance	10%, In-Network deductible applies	
3. Hospitalization	Hospital Care - Inpatient	10%	60%
	Supplies	10%	60%
4. Radiology / Laboratory Services	Radiology / Laboratory - Inpatient	10%	60%
	Radiology / Laboratory - Outpatient	10%	60%
5. Maternity and Newborn Care	Maternity Care	10%	60%
	Newborn Care	10%	60%
6. Mental Health / Substance Use Disorder Services	Mental Health / Substance Use Disorder - Inpatient	10%	60%
	Mental Health / Substance Use Disorder - Outpatient Applied Behavioral Analysis (ABA) for the treatment of autism spectrum disorders included	10%	60%
7. Rehabilitative / Habilitative Services	Habilitative - Inpatient	10%	60%
	Habilitative - Outpatient (20 visits per calendar year)	10%	60%
	Rehabilitative - Inpatient	10%	60%
	Rehabilitative - Outpatient (20 visits per calendar year)	10%	60%
8. Pediatric Services (under age 19)	**Pediatric Dental Care - Preventive:** Bitewing X-rays, Cleanings, Fluoride Treatment, Oral Exams - 2 per calendar year Sealants - 1 per permanent molar every 3 years, limitations apply	Covered in full	
	Pediatric Dental Care - Basic: Emergency / Palliative Treatment - emergency pain relief, restoration not allowed on same date of service Endodontics - such as root canal Fillings Oral Surgery - includes removal of teeth and surgical extractions Periodontal Maintenance - 4 per calendar year (in lieu of preventive cleaning) Scaling and Root Planing - 1 in a 2-year period per quadrant	20%, deductible waived	

10 Essential Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
	Pediatric Dental Care - Major: Crowns, Inlays and Onlays - 1 per tooth every 7 years Dental Implants - 4 per lifetime Dentures (full or partial), Bridges (fixed partial denture) - 1 every 5 years	50%, deductible waived	
	Pediatric Vision Care: Exams - 1 comprehensive routine eye exam per calendar year Contacts - available once per calendar year in lieu of all other lenses / frame benefits Frames - 1 frame per calendar year Lenses - 1 pair of standard lenses per calendar year; includes scratch and UV protection	$0 copay, deductible waived (for routine exam and hardware) Frames - limited to Otis & Piper Eyewear Collection	50%, deductible waived (for routine exam and hardware) Frames - no restriction on frame selection
	Find Your vision plan benefits or a VSP vision provider at regence.com or call 1 (844) 299-3041		
9. Prescription Medications	Generic (deductible waived)	$20 retail prescription* / $60 home delivery prescription	
	Preferred Brand-Name† ^	30% retail prescription / 30% home delivery prescription	
	Brand-Name	50% retail prescription / 50% home delivery prescription	
	Specialty	50% participating retail prescription	60%
10. Preventive Services	Annual Physical Exams	Covered in full	60%
	Immunizations	Covered in full	60%
	Preventive Screenings	Covered in full	60%
Other Services	Acupuncture	Not covered	
	Spinal Manipulations (18 spinal manipulations per calendar year)	10%	60%
	Virtual Care - Telehealth (doctor visits via phone or video chat when not in a healthcare facility [includes Mental Health visits] - limitations apply)	Covered in full	60%

†Deductible waived on retail or home delivery prescriptions for medications on the Optimum Value Medication List (OVML) located on Our website
**1 copay per 30-day supply*
*^**Insulin Cost Share Cap:** Retail or home delivery: $100 cap on Insured cost share per 30-day supply, deductible waived; $300 cap on Insured cost share up to 90-day supply, deductible waived*
You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and / or coinsurance
More information about prescription drug coverage is available at https://regence.com/go/2024/ID/4tier

Value-Added Services

Your Regence coverage includes access to the value-added services detailed here. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS.** For additional information regarding any of these value-added services, visit Our website or contact Customer Service.

Individual Assistance Program (IAP)	IAP is short-term, confidential counseling with no Out-of-Pocket expense. (4 mental health counseling visits per issue)
Kidney Health Management	If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD).
Mobile APP	Quick access to: ID card, chat with Customer Service, View Claims, Estimate Treatment Cost, Pharmacy pricing.
Nurse Advice	You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care 24 / 7. However, if You are experiencing a medical emergency, immediately call 911 instead.
Pregnancy Program	Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions, the Pregnancy Program can help.
Regence Advantages	Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services.
Regence Empower	Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle.

Provider Networks

There are several provider networks in Your state. Please note that these networks are not interchangeable and support different providers. **Your enrolled network is Individual and Family Network**. To find providers in Your network, please sign into Your account and use Our provider search tool: https://regence.com/go/ID/IFN.

Out-of-Area Services

Outside of the service area, Insureds have In-Network benefits for Ambulance, Emergency Room and Urgent Care only, in addition to approved Out-of-Network coverage. Additionally, Insureds will receive In-Network benefits at Blue Cross and / or Blue Shield (Blue Plan) Urgent Care facilities across the country through the BlueCard® Program and worldwide through the Blue Cross Blue Shield Global® Core program. No other services are covered worldwide. Out-of-Network, You may be balance billed. Call 1 (800) 810 BLUE (2583) to learn how to get access.

Frequently Asked Questions

How is my privacy protected?	Regence is committed to the confidentiality and security of Your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of Your personal information. You can view Our full privacy practices online at https://regence.com/go/ID/IFN.
Is there a cost for "Covered in full"?	No, if Your benefit is covered in full there is no copay or deductible up to the plan limit.
What if I need access to specialty care? Do I need a referral?	You can receive care from any In-Network provider without a referral. For some services, prior authorization may be required.
What key Utilization Management (UM) process does the plan use?	Utilization Management is the way We review the type and amount of care You receive and includes pre-service (prior authorization), concurrent review (including urgent concurrent review), and post-service review. You can find more information online at https://www.regence.com/go/UM.

Definitions

Allowed Amount: The lower price an In-Network provider has agreed to accept as payment in full for the care provided to You.

Balance Billing: The difference between the provider's charge and what Your plan pays.

Coinsurance: Your share of the cost for care after You pay any deductible. It's usually a percentage of the total cost of care (for example, 20%).

Copay: A flat dollar amount You pay for care, like a doctor's visit, hospital outpatient visit or prescription. You will usually pay it when You go in for care.

Deductible: The amount You pay out of Your own pocket each calendar year before Your plan begins to pay. Some services, such as preventive care, are sometimes covered at 100% before You have met Your deductible.

Drug List (also known as a formulary): A list of prescription medications that Your plan covers. It includes brand-name, generic and specialty drugs.

Exclusive Provider Organization Networks (EPOs): EPOs cover only In-Network care. This means You are responsible for 100% of the costs of any Out-of-Network care (excluding emergency services). To avoid surprise bills, You must be careful to always see an In-Network provider.

Explanation of Benefits (EOB): A statement that explains how much Regence paid toward a claim and how much You owe the provider for care.

Generic Drugs: A prescription medication approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name version. Generally, a generic drug works the same as a brand-name drug and usually costs less.

In-Network Provider: A facility or health professional contracted with Your plan. You usually have lower Out-of-Pocket costs when You use In-Network providers.

Out-of-Network Provider: A facility or health professional not contracted with Your plan. You usually have higher Out-of-Pocket costs when You use Out-of-Network providers.

Out-of-Pocket Maximum: The most You will have to pay in deductible, coinsurance and copays per calendar year. Once You have met this maximum, Regence pays 100% of Your covered care for the rest of the calendar year.

Point of Service (POS): A type of managed care health insurance that has the characteristics of an EPO with lean Out-of-Network coverage. It has a provider-focused network that lowers Out-of-Pocket costs and provides medical savings, while still enabling access to providers outside of the network, but with higher Out-of-Pocket costs.

Primary Care Provider (PCP): A doctor or other health professional You see as the first point of contact for medical care and Your partner in managing Your health care.

Specialist: An expert in a particular area of medicine, for example, a dermatologist, allergist or cardiologist.

Telehealth: Care that You receive from a doctor over the phone or computer for routine needs and ailments.

General Exclusions

Activity Therapy: The following activity therapy services are not covered:

- creative arts;
- play;
- dance;
- aroma;
- music;
- equine or other animal-assisted;
- recreational or similar therapy; and
- sensory movement groups.

General Exclusions

Acupuncture

Adventure, Outdoor, or Wilderness Interventions and Camps: Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;
- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:
  - blindness;
  - deafness / hardness of hearing;
  - a Mental Health Condition; or
  - a Substance Use Disorder.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service in this Policy.

Assisted Reproductive Technologies: Assisted reproductive technologies, regardless of underlying condition or circumstance, are not covered, including, but not limited to:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;
- other artificial means of conception; or
- any associated surgery, medications, testing or supplies.

Aviation: Except for an injured Insured that is a passenger on a scheduled commercial airline flight or air ambulance, services in connection with Injuries sustained in aviation accidents (including accidents occurring in flight or in the course of take-off or landing) are not covered.

Breast Reduction: Except when following a Medically Necessary mastectomy, to the extent required by law, breast reductions are not covered. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

Certain Therapy, Counseling and Training: Except as provided in the Individual Assistance Program (IAP), the following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling; and
- job skills or sensitivity training.

Conditions Caused by Active Participation in a War or Insurrection: The treatment of any condition caused by or arising out of an Insured's active participation in a war or insurrection.

Conditions Incurred in or Aggravated During Performances in the Uniformed Services: The treatment of any Insured's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Cosmetic / Reconstructive Services and Supplies: Except for treatment of the following, Cosmetic and / or reconstructive services and supplies are not covered:

- a Congenital Anomaly;
- to restore a physical bodily function lost as a result of Illness or Injury; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

"Reconstructive" means services, procedures or surgery performed on abnormal structures of the body, caused by Congenital Anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Counseling in the Absence of Illness: Except as required by law, counseling in the absence of Illness is not covered.

Custodial Care: Non-skilled care and helping with activities of daily living.

Dental Services: Except as provided in the Pediatric Dental Services or the Repair of Teeth benefits, Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

Elective Abortions: Elective abortions are not covered.
"Elective abortion" means an abortion for any reason other than to preserve the life of the Insured upon whom the abortion is performed. Coverage for non-elective abortions is provided in the Termination of Pregnancy benefit.

Facilities Without a Provider Legally Required to be on Duty: Admission and treatment in a setting where neither a Physician nor licensed nurse is legally required to be on duty at all times that a patient is admitted.

Family Counseling: Except when provided as part of the treatment for a child or adolescent with a covered diagnosis, family counseling is not covered.

Fees, Taxes, Interest: Except as required by law, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Provider might bill;
- excise, sales or other taxes;
- surcharges;
- tariffs;

- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

Gene Therapy or Adoptive Cellular Therapy

Government Programs: Except as required by law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with Us, benefits that are covered (or would be covered in the absence of this Policy) by any federal, state or government program are not covered.

Additionally, except as listed below, government facilities or government facilities outside the Service Area are not covered:
- facilities contracting with the local Blue Cross and / or Blue Shield plan; or
- as required by law for emergency services.

Hearing Aids and Other Devices: Except for cochlear implants or as provided in the Hearing Loss benefit, hearing aids (externally worn or surgically implanted) or other hearing devices are not covered.

Hypnotherapy and Hypnosis Services: Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:
- treatment of painful physical conditions;
- Mental Health Conditions;
- Substance Use Disorders; or
- for anesthesia purposes.

Illegal Activity: Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by an Insured's **voluntary participation in** an activity where the Insured is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, We may recover the payment from the person We paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies: Services, substances and supplies that are illegal as defined by state or federal law.

Individualized Education Program (IEP): Services or supplies, including, but not limited to, supplementary aids and supports as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility: Except to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to:
- surgery;
- uterine transplants;
- fertility medications; and
- other medications associated with fertility treatment.

Investigational Services: Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:
- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by an Investigational protocol.

Liposuction for the Treatment of Lipedema

Motor Vehicle Coverage and Other Available Insurance: When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to an Insured (whether or not the Insured makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:
- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, Our Coordination of Benefits provision shall apply);
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Insured is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care: Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:
- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Non-Therapeutic Continuous Glucose Monitors

Obesity or Weight Reduction / Control: Except as provided in the Nutritional Counseling benefit, as required by law or for treatment of obesity-related comorbid medical conditions (for example, diabetes, high blood pressure and heart disease), services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:
- medical treatment;
- medications;
- surgical treatment (including treatment of complications, revisions and reversals); or
- programs.

Orthognathic Surgery: Except for treatment of the following, orthognathic surgery is not covered:
- orthognathic surgery due to an Injury;
- sleep apnea (specifically, telegnathic surgery); or
- Congenital Anomaly.

"Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

"Telegnathic surgery" means skeletal (maxillary, mandibular and hyoid) advancement to anatomically enlarge and physiologically stabilize the pharyngeal airway to treat obstructive sleep apnea.

Over-the-Counter Contraceptives: Except as provided in the Prescription Medications Section or as required by law, over-the-counter contraceptive supplies are not covered.

Personal Items: Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, environmental control, education or general physical fitness are not covered, including, but not limited to:

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment: Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to:

- hot tubs; or
- membership fees to spas, health clubs or other such facilities.

Private-Duty Nursing: Private-duty nursing, including ongoing shift care in the home.

Provider-Administered Specialty Drugs: Provider-Administered Specialty Drugs that are not obtained through the designated Specialty Pharmacy for Provider-Administered Specialty Drugs are not covered.

Reversals of Sterilizations: Services and supplies related to reversals of sterilization.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs: Except as provided in the Medical Benefits Section or for services provided without a separate charge in connection with Covered Services that train or educate an Insured, self-help, non-medical self-care, and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs that:
  - teach a person how to use Durable Medical Equipment;
  - teach a person how to care for a family member; or
  - provide a supportive environment focusing on the Insured's long-term social needs when rendered by individuals who are not Providers.

Services and Supplies Provided by a Member of Your Family: Services and supplies provided to You by a member of Your immediate family are not covered. "Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary: Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes: Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered. Administrative or qualification purposes include, but are not limited to:

- admission to or remaining in:
  - school; a camp; a sports team; the military; or any other institution.
- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:
  - employment or return to work; marriage; insurance; occupational injury benefits; licensure; or certification.
- travel, immigration or emigration.

Sexual Dysfunction: Except as provided in the Mental Health Services benefit, treatment, services and supplies are not covered for or in connection with sexual dysfunction regardless of cause.

Temporomandibular Joint (TMJ) Disorder Treatment: Services and supplies provided for TMJ disorder treatment.

Third-Party Liability: Services and supplies for treatment of Illness, Injury or health condition for which a third-party is or may be responsible.

Travel and Transportation Expenses: Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits Section, travel and transportation expenses are not covered.

Travel Immunizations: Immunizations for travel, occupation or residency in a foreign country.

Varicose Vein Treatment: Except as provided in the Other Professional Services benefit, treatment of varicose veins is not covered.

Vision Care: Except as provided in the Pediatric Vision Services Section, vision care services are not covered, including, but not limited to:

- routine eye examinations;

General Exclusions

- vision hardware;
- visual therapy;
- training and eye exercises;
- vision orthoptics;
- surgical procedures to correct refractive errors / astigmatism; and
- reversals or revisions of surgical procedures which alter the refractive character of the eye.

Wigs: Wigs or other hair replacements regardless of the reason for hair loss or absence.

Work-Related Conditions: Except when an Insured is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered. This includes any claims resolved as a result of a disputed claim settlement. If an Illness or Injury could be considered work-related, an Insured will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

Pediatric Dental Exclusions

Adjustments: Adjustment of a denture or bridgework which is done within six months after insertion by the same Dentist who installed the denture or bridgework.

Aesthetic Dental Procedures: Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth.

Bone Grafts: Bone grafts done in connection with extractions, apicoectomies or non-covered / ineligible implants.

Cone Beam Imaging / MRI Procedures

Cosmetic / Reconstructive Services and Supplies: Except for the following, Cosmetic and / or reconstructive services and supplies are not covered:

- Dentally Appropriate services and supplies to treat a Congenital Anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

"Reconstructive" means services, procedures or surgery performed on abnormal structures of the body, caused by Congenital Anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Decay Prevention: Supplies and materials to prevent decay are not covered, including, but not limited to:

- toothpaste;
- fluoride gels;
- dental floss; and
- teeth whiteners.

Duplicate Services: Services submitted by a Dentist which are for the same services performed on the same date for the same Insured by another Dentist.

Experimental or Investigational Services

Fabrication of Athletic Mouth Guard

Facility Expenses: Services and supplies related to facility expenses are not covered, including, but not limited to:

- those performed by a Dentist who is compensated by a facility for similar Covered Services performed for an Insured; and
- costs or any additional fees that the Dentist or Hospital charges for treatment at the Hospital (inpatient or outpatient).

Failure to Comply: Services and supplies resulting from Your failure to comply with professionally prescribed treatment.

Gold-Foil Restorations

Nitrous Oxide

Oral Hygiene and Dietary Instructions

Oral Sedation

Orthodontic Dental Services: Except when Medically Necessary, orthodontic services and supplies are not covered, including, but not limited to:

- correction of malocclusion;
- craniomandibular orthopedic treatment;
- other orthodontic treatment;
- preventive orthodontic procedures;
- procedures for tooth movement, regardless of purpose; and
- repair of damaged orthodontic appliances.

Plaque Control Programs

Precision Attachments, Personalization, Precious Metal Bases and Other Specialized Techniques

Provisional, Temporary and Duplicate Devices or Appliances

Replacements: Replacement of any lost, stolen or broken dental appliance, including, but not limited to, dentures or retainers.

Sealants: Except as provided for permanent molars, sealants are not covered.

Separate Charges: Services and supplies that may be billed as separate charges (services that should be included in the billed procedure) are not covered, including, but not limited to:

- any supplies;
- local anesthesia; and
- sterilization (office infection control charges).

Services and Supplies to Alter Vertical Dimension and / or Restore or Maintain the Occlusion: Services and supplies to alter vertical dimension and / or restore or maintain the occlusion are not covered, including, but not limited to:

Pediatric Dental Exclusions

- equilibration;
- periodontal splinting;
- full mouth rehabilitation; and
- restoration for misalignment of teeth.

Services and Supplies Which the Insured Would Have No Legal Obligation to Pay in the Absence of this Coverage

Services and Treatment Not Prescribed By or Under the Direct Supervision of a Dentist

Services Provided by Certain Entities: Services and treatment are not covered when received from a dental or medical department maintained by or on behalf of:

- an employer;
- mutual benefit association;
- labor union;
- trust;
- Veterans Administration Hospital; or
- similar person or group.

Specialized Procedures and Techniques

Temporomandibular Joint (TMJ) Disorder Treatment: Services and supplies provided in connection with TMJ disorder treatment.

Topical Medicament Center

Pediatric Vision Exclusions

Certain Contact Lens Expenses

- artistically-painted or nonprescription contact lenses;
- contact lens modification, polishing or cleaning;
- refitting of contact lenses after the initial (90-day) fitting period;
- additional office visits associated with contact lens pathology; and
- contact lens insurance policies or service agreements.

Corneal Refractive Therapy (CRT): Reversals or revisions of surgical procedures which alter the refractive character of the eye, including orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

Corrective Vision Treatment of an Experimental Nature

Costs for Services and / or Supplies Exceeding Benefit Allowances

Lens Enhancements: Except as provided in the Vision Hardware benefit, lens enhancements are not covered, including, but not limited to:

- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- Cosmetic lenses;
- laminated lenses;
- oversize lenses; or
- standard, premium and custom progressive multifocal lenses.

Medical or Surgical Treatment of the Eyes: Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Orthoptics or Vision Training: Except as provided in the Low Vision benefits, orthoptics, vision training and any associated supplemental testing are not covered.

Plano Lenses (Less Than a ± .50 Diopter Power)

Replacements: Replacement of any lost, stolen or broken lenses and / or frames.

Two Pair of Glasses in Lieu of Bifocals

Prescription Medication Exclusions

Biological Sera, Blood or Blood Plasma

Bulk Powders: Except as included on Our Drug List and presented with a Prescription Order, bulk powders are not covered.

Cosmetic Purposes: Prescription Medications used for Cosmetic purposes, including, but not limited to:

- removal, inhibition or stimulation of hair growth, except as related to a covered medical condition;
- anti-aging; or
- repair of sun-damaged skin.

Devices or Appliances: Except as provided in the Medical Benefits Section, devices or appliances of any type, even if they require a Prescription Order are not covered.

Diagnostic Agents: Except as provided in the Medical Benefits Section, diagnostic agents used to aid in diagnosis rather than treatment are not covered.

Digital Therapeutics: Except as included on Our Drug List and presented with a Prescription Order, digital therapeutics are not covered.

Foreign Prescription Medications: Except for the following, foreign Prescription Medications are not covered:

- Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States; or
- Prescription Medications You purchase while residing outside the United States.

Prescription Medication Exclusions

These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered in this section if obtained in the United States.

General Anesthetics: Except as provided in the Medical Benefits Section, general anesthetics are not covered.

Medical Foods: Except as provided in the Medical Benefits Section, medical foods are not covered.

Medications that are Not Considered Self-Administrable: Except as provided in the Medical Benefits Section or as specifically indicated in this Prescription Medications Section, medications that are not considered self-administrable are not covered.

Nonprescription Medications: Except for the following, nonprescription medications that by law do not require a Prescription Order are not covered:

- medications included on Our Drug List;
- medications approved by the FDA; or
- a Prescription Order by a Physician or Practitioner.

Nonprescription medications include, but are not limited to:

- over-the-counter medications;
- vitamins;
- minerals;
- food supplements;
- homeopathic medicines;
- nutritional supplements; and
- any medications listed as over-the-counter in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

Prescription Medications Dispensed in a Facility: Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed by this benefit if obtained from a Pharmacy.

Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)

Prescription Medications Not Approved by the FDA

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not on the Drug List: Except as provided through the Drug List Exception Process provision, Prescription Medications that are not on the Drug List are not covered.

Prescription Medications Not within a Provider's License: Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications with Therapeutic Alternatives: Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives.

Prescription Medications without Examination: Except as provided in the Virtual Care benefit, whether the Prescription Order is provided by mail, telephone, internet or some other means, Prescription Medications without a recent and relevant in-person examination by a Provider, are not covered. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe:

- an opioid antagonist to an Insured who is at risk of experiencing an opiate-related overdose; or
- an epinephrine auto-injector to an Insured who is at risk of experiencing anaphylaxis.

An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

This benefit summary provides a brief description of Your plan benefits, limitations and / or exclusions under Your plan and is not a guarantee of payment. Once enrolled, You can view Your benefits policy online at regence.com. **PLEASE REFER TO YOUR BENEFITS POLICY OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND / OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY**. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary.

Regence BlueShield of Idaho, Inc. - Medical and Pediatric Dental Customer Service
1 (888) 232-5763 - TTY: 711 | 1602 21st Avenue, Lewiston, ID 83501 | regence.com

Vision Service Plan - Pediatric Vision Customer Service
1 (844) 299-3041 (hearing impaired: 1 (800) 428-4833) | PO Box 997100, Sacramento, CA 95899-7100 | regence.com

Regence Dental and Vision

Regence BlueShield of Idaho, Inc.

Effective January 1, 2024 through December 31, 2024

Regence BlueShield of Idaho is an Independent Licensee of the BlueCross and BlueShield Association

Dental Coverage

This plan includes preventive and diagnostic services, as well as restorative and major services. After satisfaction of the deductible, this plan will provide payment for the services at the percentages listed below up to the Calendar Year maximum. Payment of benefits is based on a percentage of the Allowed Amount. In-Network providers have agreed to accept the Allowed Amounts as payment for services. Services of an Out-of-Network provider are based on a percentage of the Allowed Amount. The Insured will be responsible for any additional charges over the Allowed Amount.

Cost Share Details (limited to age 19 and older)		**In-Network**	**Out-of-Network**
Annual Deductible	The total deductible You pay per calendar year		$50 Individual $150 Family
Annual Limit	This plan will pay for Covered Services only up to this limit during each coverage period, even if Your own need is greater. You are responsible for all expenses above this limit. If You use less than the Benefit Maximum in the first calendar year, $250 will be added to the $750 Benefit Maximum for the second year. In subsequent years, if You use no more than the $750 Benefit Maximum, an additional $250 will be added for the following year. The total combined Benefit Maximum for any year cannot exceed $1,500 per Individual.		$750 Individual

Preventive and Diagnostic Dental Services		**What You Pay**
Cleanings and Examinations	Cleanings - 2 per calendar year with a 3rd being covered with qualifying diagnosis Preventive oral examinations - 2 per calendar year Problem focused oral examinations	Covered in full
X-rays	Bitewing x-rays - 2 sets per calendar year Complete intra-oral mouth x-ray - Once in a 3-year period Panoramic mouth x-ray - Once in a 3-year period	Covered in full

Basic Dental Services (*unless stated otherwise, a deductible applies*)		**What You Pay**
Complex Oral Surgery	Including surgical extractions of teeth	20%
Emergency and Other Basic Dental Services	Emergency treatment for pain relief	20%
Endodontic Services	Services including root canal treatment, pulpotomy and apicoectomy	20%
Periodontal Services	Periodontal maintenance - 2 per calendar year (in lieu of preventive cleanings) with a 3rd being covered with qualifying diagnosis Debridement - Once in a 3-year period Scaling and root planing - 1 in a 2-year period per quadrant	20%

6-month waiting period for enrollees with no prior Regence dental coverage

Major Dental Services (*unless stated otherwise, a deductible applies*)		**What You Pay**
Bridges (fixed partial dentures)	Replacement once per 7 years after placement	50%
Crowns, Inlays and Onlays	Replacement once (per tooth) 7 years after placement	50%
Dentures (full and partial)	Replacement 7 years after placement	50%
Implants (endosteal)	4 implants per Insured lifetime	50%

12-month waiting period for enrollees with no prior Regence dental coverage

Vision Coverage

Vision Benefits (limited to age 19 and older)		VSP Network	Out-of-Network
Contact Lens Evaluations and Fitting Examinations	1 contact lens evaluation and fitting examination per Insured per calendar year	$60 copay	See Vision Lenses
Contact Lens	Elective contact lenses are available once during any calendar year in lieu of all other lenses and frame benefits available. Insured will not be eligible for any lenses and / or frames again until the next calendar year	No charge for VSP doctors	Contact lens allowance up to: Elective contacts, combined with fitting / evaluation services $105 Necessary contacts, including fitting / evaluation services $210
Routine Vision Examinations	1 comprehensive routine eye examination per Insured per calendar year	$0 copay	Allowance up to $45
Vision Frames	1 frame per calendar year	No charge up to $150 VSP provider limit or $80 VSP approved wholesale / retail vendor limit	Allowance up to $70
Vision Lenses	1 pair of standard glass or plastic lenses per calendar year for either: Single vision lenses; Lined bifocal (or standard progressive) lenses; Lined trifocal lenses; Lenticular lenses; or Contact lenses	No charge for VSP doctors	Lens allowance up to: Single vision lenses $30 Lined bifocal and standard progressive lenses $50 Lined trifocal lenses $65 Lenticular lenses $100

Additional Discounts

You are entitled to receive a 20% discount toward the purchase of non-covered materials from any VSP Doctor when a complete pair of glasses is dispensed. You are also entitled to receive a 15% discount off of contact lens examination services from any VSP Doctor beyond the covered examination. VSP Doctors may request an additional examination at a discount within 12 months if necessary.

Discount of 15%-20% off or 5% off a promotional offer for laser surgery.

Discounts are applied to the VSP Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye examination. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS VISION PLAN, BUT ARE NOT INSURANCE.** Please refer to Your benefits booklet or Summary Plan Description for complete details.

Limitations

- discounts do not apply to vision care benefits obtained from Out-of-Network provider;
- 20% discount applies only to complete pairs of glasses; and
- discounts do not apply to sundry items, for example, contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

Dental Exclusions

Aesthetic Dental Procedures: Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

Antimicrobial Agents: Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Collection of Cultures and Specimens: Collection of cultures and specimens, including, but not limited to:

- saliva; or
- tissue of the oral cavity.

Connector Bar or Stress Breaker

Desensitizing: Application of desensitizing medicaments or desensitizing resin for cervical and / or root surface.

Diagnostic Casts or Study Models

Duplicate X-Rays

Facility Charges: Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

Fractures of the Mandible (Jaw): Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Home Visits

Implants: Except as provided in the Major Dental Services benefit, implants and any associated services and supplies are not covered (whether or not the implant itself was covered), including, but not limited to:

- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lift;

Dental Exclusions

- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
- radiographic / surgical implant index; and
- unspecified implant procedures.

Indirect Pulp Capping and Pulp Vitality Tests

Medications and Supplies: Charges in connection with medications and supplies, including, but not limited to:

- take-home drugs;
- pre-medications; and
- therapeutic drug injections.

Nitrous Oxide

Occlusal Treatment: Dental occlusion services and supplies are not covered, including, but not limited to:

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

Oral Surgery: Oral surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Orthodontic Dental Services: Orthodontic services and supplies are not covered, including, but not limited to:

- correction of malocclusion;
- craniomandibular orthopedic treatment;
- other orthodontic treatment;
- preventive orthodontic procedures;
- procedures for tooth movement, regardless of purpose; and
- repair of damaged orthodontic appliances.

Pediatric Dental Services and Supplies: Dental Services and supplies for Insureds 18 years of age and younger.

Photographic Images

Pin Retention in Addition to Restoration

Precision Attachments

Prosthesis: Dental prosthesis services and supplies are not covered, including, but not limited to:

- maxillofacial prosthetic procedures; and
- modification of removable prosthesis following implant surgery.

Provisional Splinting

Replacements: Replacement of any lost, stolen or broken dental appliance, including, but not limited to, dentures or retainers.

Sealants

Separate Charges: Services and supplies that may be billed as separate charges (services that should be included in the billed procedure) are not covered, including, but not limited to:

- any supplies;
- local anesthesia; and
- sterilization.

Services Performed in a Laboratory

Space Maintainers

Surgical Procedures: Services and supplies provided in connection with the following surgical procedures are not covered:

- exfoliative cytology sample collection or brush biopsy;
- incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
- radical resection of maxilla or mandible;
- removal of nonodontogenic cyst, tumor or lesion;
- surgical stent; or
- surgical procedures for isolation of a tooth with rubber dam.

Temporomandibular Joint (TMJ) Disorder Treatment: Services and supplies provided in connection with TMJ disorder treatment.

Tooth Transplantation: Services and supplies provided in connection with tooth transplantation are not covered, including, but not limited to:

- reimplantation from one site to another;
- splinting; or
- stabilization.

Topical Fluoride

Veneers

Vision Exclusions

Certain Contact Lens Expenses

- artistically-painted or non-prescription contact lenses;

- contact lens modification, polishing or cleaning;
- refitting of contact lenses after the initial (90-day) fitting period;
- additional office visits associated with contact lens pathology; and
- contact lens insurance policies or service agreements.

Corneal Refractive Therapy (CRT): Reversals or revisions of surgical procedures which alter the refractive character of the eye, including orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

Corrective Vision Treatment of an Experimental Nature

Costs for Services and / or Supplies Exceeding Benefit Allowances

Lens Enhancements: Except as provided in the Vision Hardware benefit, lens enhancements are not covered, including, but not limited to:
- anti-reflective coating;
- color coating;
- mirror coating;
- scratch coating;
- blended lenses;
- Cosmetic lenses;
- laminated lenses;
- oversize lenses;
- premium and custom progressive multifocal lenses;
- photochromic lenses;
- tinted lenses, except Pink #1 and Pink #2; or
- UV (ultraviolet) protected lenses.

Medical or Surgical Treatment of the Eyes: Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Orthoptics or Vision Training: Except as provided in the Low Vision benefit, orthoptics, vision training and any associated supplemental testing are not covered.

Pediatric Vision Services and Supplies: Vision Services and supplies for Insureds 18 years of age and younger.

Plano Lenses (Less Than a ± .50 Diopter Power)

Replacements: Replacement of any lost, stolen or broken lenses and / or frames.

Services and / or Supplies Not Described as Covered in this Vision Benefit

Services and Supplies That Are Not Medically Necessary: Services and supplies that are not Medically Necessary for the treatment of the diagnosis (or correction) of visual acuity.

Two Pair of Glasses Instead of Bifocals

General Exclusions

Conditions Caused by Active Participation in a War or Insurrection: The treatment of any condition caused by or arising out of an Insured's active participation in a war or insurrection.

Conditions Incurred in or Aggravated During Performances in the Uniformed Services: The treatment of any Insured's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Cosmetic / Reconstructive Services and Supplies: Except for Dentally Appropriate or Medically Necessary treatment of the following, Cosmetic and/or reconstructive services and supplies are not covered:
- to treat a Congenital Anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

"Reconstructive" means services, procedures or surgery performed on abnormal structures of the body, caused by Congenital Anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Facility Charges: Services and supplies provided in connection with facility services.

Fees, Taxes, Interest: Except as required by law, the following fees, taxes and interest are not covered: charges for shipping and handling, postage, interest or finance charges that a Provider might bill; excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity.

Government Programs: Except as required by law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with Us, benefits that are covered (or would be covered in the absence of this Policy) by any federal, state or government program are not covered.

Additionally, except as required by law for emergency services, government facilities outside the Service Area are not covered.

Illegal Activity: Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by an Insured's **voluntary participation in** an activity where the Insured is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, We may recover the payment from the person We paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies: Services, substances and supplies that are illegal as defined by state or federal law.

Investigational Services: Investigational services are not covered, including, but not limited to: services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and any services or supplies provided by an Investigational protocol.

General Exclusions

Motor Vehicle Coverage and Other Available Insurance: When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to an Insured (whether or not the Insured makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, Our Coordination of Benefits provision shall apply);
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Insured is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care: Non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Personal Items: Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, aesthetics or other nontherapeutic purposes.

Self-Help, Self-Care, Training or Instructional Programs: Except for services provided without a separate charge in connection with Covered Services that train or educate an Insured, self-help, non-dental self-care, non-medical self-care, non-vision self-care and training or instructional programs are not covered.

Services and Supplies Provided by a Member of Your Family: Services and supplies provided to You by a member of Your immediate family are not covered. "Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Third-Party Liability: Services and supplies for treatment of Illness, Injury or health condition for which a third-party is or may be responsible.

Travel and Transportation Expenses

Vision Care: Except as provided in this Policy, vision care services are not covered, including, but not limited to: visual therapy; training and eye exercises; vision orthoptics; surgical procedures to correct refractive errors / astigmatism; and reversals or revisions of surgical procedures which alter the refractive character of the eye.

Work-Related Conditions: Except when an Insured is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered. This includes any claims resolved as a result of a disputed claim settlement.

If an Illness or Injury could be considered work-related, an Insured will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

This benefit summary provides a brief description of Your plan benefits, limitations and / or exclusions under Your plan and is not a guarantee of payment. Once enrolled, You can view Your benefits policy online at regence.com. **PLEASE REFER TO YOUR BENEFITS POLICY OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND / OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY**. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary.

Customer Service
1 (888) 232-5763 - TTY: 711 | 1602 21st Avenue, Lewiston, ID 83501 | regence.com

Vision
Provider and Benefit Inquiries: 1 (844) 299-3041 | PO Box 997100, Sacramento, CA 95899-7100 | regence.com

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

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