

Regence Standard Silver Plan Individual and Family Network

Effective January 1, 2023 through December 31, 2023



Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Cost Share Details		In-Network	Out-of-Network
Annual Medical Deductible	The total deductible you pay per calendar year	\$4,800 Individual \$9,600 Family	Not covered
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	\$9,100 Individual \$18,200 Family	Not covered

10 Essential Benefits <i>(unless stated otherwise, a deductible applies)</i>		What You Pay	
		In-Network	Out-of-Network
1. Ambulatory Care	Primary Care Visits (for Illness or Injury)	\$40 copay per visit, deductible waived	Not covered
	Specialist Visits	\$80 copay per visit, deductible waived	Not covered
	Urgent Care Visits	\$70 copay per visit, deductible waived	
2. Emergency Care	Emergency Room Care	30%	
	Ambulance	30%	
3. Hospitalization	Hospital Care - Inpatient	30%	Not covered
	Supplies	30%	Not covered
4. Radiology / Laboratory Services	Radiology / Laboratory - Inpatient	30%	Not covered
	Radiology / Laboratory - Outpatient	30%	Not covered
5. Maternity and Newborn Care	Maternity Care	30%	Not covered
	Newborn Care	30%	Not covered
	Newborn Home Visits - within 6 months of age, at least one visit during first 3 months, with up to 3 more available	Covered in full	Not covered
6. Mental Health / Substance Use Disorder Services	Mental Health / Substance Use Disorder - Inpatient	30%	Not covered
	Mental Health / Substance Use Disorder - Outpatient	\$40 copay per outpatient office / psychotherapy visit, deductible waived	Not covered
7. Rehabilitative / Habilitative / Biofeedback Services	Habilitative - Inpatient (30 days per calendar year)	30%	Not covered
	Habilitative - Outpatient (30 visits per calendar year)	\$40 copay per visit, deductible waived	Not covered
	Rehabilitative - Inpatient (30 days per calendar year)	30%	Not covered
	Rehabilitative - Outpatient (30 visits per calendar year)	\$40 copay per visit, deductible waived	Not covered
	Biofeedback - (10 visits per lifetime)	\$40 copay per visit, deductible waived	Not covered
8. Pediatric Services (under age 19)	Dental Care	Not covered	
	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 Frames - limited to Otis & Piper Eyewear Collection	Not covered

Find your vision plan benefits or a VSP vision provider at regence.com or call 1 (844) 299-3041

9. Prescription Medications

Preferred Generic (deductible waived)	\$15 retail prescription* / \$45 home delivery (mail-order) prescription
Generic (deductible waived)	25% retail prescription / 25% home delivery (mail-order) prescription
Preferred Brand (deductible waived)	\$60 retail prescription* / \$180 home delivery (mail-order) prescription
Brand (deductible waived)	50% retail prescription / 50% home delivery (mail-order) prescription
Preferred Specialty (deductible waived)	40% participating retail prescription
Specialty (deductible waived)	50% participating retail prescription

*1 copay per 30-day supply

Insulin Cost Share Cap: Retail or home delivery (mail-order): \$80 cap on member cost share per 30-day supply, deductible waived; \$240 cap on member cost share up to 90-day supply, deductible waived

30% for each self-administered Cancer Chemotherapy medication

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/2023/OR/6tier>

10. Preventive Services

Annual Physical Exams	Covered in full	Not covered
Immunizations	Covered in full	Not covered
Preventive Screenings	Covered in full	Not covered

Other Services

Accidental Death Benefit - subject to terms and conditions	\$10,000 per enrolled adult \$2,500 per enrolled child	
Acupuncture (12 visits per calendar year)	\$40 copay per visit, deductible waived	Not covered
Spinal Manipulations (20 visits per calendar year)	\$40 copay per visit, deductible waived	Not covered
Virtual Care - Store and Forward (asynchronous communications such as text or fax - limitations apply)	\$40 copay per visit, deductible waived	Not covered
Virtual Care - Telehealth (doctor visits via phone or video chat when not in a healthcare facility [includes Mental Health visits] - limitations apply)	\$40 copay per visit, deductible waived	Not covered

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 Web site 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)
Contact Crisis Counseling hotline directly at 1 (866) 750-1327

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. Pregnancy Program can help, call 1 (888) JOY-BABY (569-2229)

Regence Advantages

Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services

Value-Added Services

Regence Empower

Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle

Available 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/OR/IFN>.

Out-of-Area Services

Outside of the service area, members have In-Network benefits for Ambulance, Emergency Room and Urgent Care only, in addition to approved Out-of-Network coverage. Additionally, members 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 BlueCross BlueShield Global™ Core Program. Any other services will not be covered when processed through any Inter-Plan arrangements. 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/OR/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'll 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've 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'll have to pay in deductible, coinsurance and copays per calendar year. Once you've 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.

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) 675-6570 - TTY: 711 | 100 SW Market Street, Portland, OR 97201 | 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'déé', t'áá jiik'eh, éí ná hóló, kojí' 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 ដោយមិនគិតល្អល 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)

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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 (टिडिवाइ: 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, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີຜ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajjila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر بہ زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)