Regence Standard Silver Plan Individual and Family Network

Effective January 1, 2024 through December 31, 2024

Regence BlueCross BlueShield of Oregon 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	$5,500 Individual $11,000 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	$9,450 Individual $18,900 Family	Not covered
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)	First 3 Primary Care, Behavioral Health, and Virtual Care visits combined, $5 copay per visit, deductible waived After 3 visits, $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. Behavioral Health Services	Behavioral Health Services - Inpatient	30%	Not covered
	Behavioral Health Services - Outpatient	First 3 Primary Care, Behavioral Health, and Virtual Care visits combined, $5 copay per visit, deductible waived After 3 visits, $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

10 Essential Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	**Out-of-Network**
	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)	**Pediatric Dental Care**	Not covered	
	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	Not covered
	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)	$15 retail prescription* / $45 home delivery prescription	
	Preferred Brand-Name (deductible waived)	$60 retail prescription* / $180 home delivery prescription	
	Brand-Name (deductible waived)	50% retail prescription / 50% home delivery prescription	
	Specialty (deductible waived)	40% participating retail prescription	

**1 copay per 30-day supply*
Insulin Cost Share Cap: *Retail or home delivery: $85 cap on Insured cost share per 30-day supply, deductible waived; $255 cap on Insured 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/2024/OR/4tier

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	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 - Telehealth (doctor visits via phone or video chat when not in a healthcare facility [includes Behavioral Health visits] - limitations apply)	First 3 Primary Care, Behavioral Health, and Virtual Care visits combined, $5 copay per visit, deductible waived After 3 visits, $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 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.

Value-Added Services	
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.

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, 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/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 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.

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

Regence Dental and Vision

Effective January 1, 2024 through December 31, 2024

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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 exam. VSP Doctors may request a discounted additional exam 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 to complete pairs of glasses only; and
- discounts do not apply to sundry items, for example, contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

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

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)

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

توجه: اگر به 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 فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)