

Regence Silver 6500 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	\$6,500 Individual \$13,000 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)	\$10 copay per visit, deductible waived	Not covered
	Specialist Visits	\$70 copay per visit, deductible waived	Not covered
	Urgent Care Visits	\$70 copay per visit, deductible waived	
2. Emergency Care	Emergency Room Care	10%	
	Ambulance	10%	
3. Hospitalization	Hospital Care - Inpatient	10%	Not covered
	Supplies	10%	Not covered
4. Radiology / Laboratory Services	Radiology / Laboratory - Inpatient	10%	Not covered
	Radiology / Laboratory - Outpatient	10%	Not covered
5. Maternity and Newborn Care	Maternity Care	10%	Not covered
	Newborn Care	10%	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	10%	Not covered
	Behavioral Health Services - Outpatient	\$10 copay per outpatient office / psychotherapy visit, deductible waived	Not covered
7. Rehabilitative / Habilitative / Biofeedback Services	Habilitative - Inpatient (30 days per calendar year)	10%	Not covered
	Habilitative - Outpatient (30 visits per calendar year)	10%	Not covered
	Rehabilitative - Inpatient (30 days per calendar year)	10%	Not covered
	Rehabilitative - Outpatient (30 visits per calendar year)	10%	Not covered
	Biofeedback - (10 visits per lifetime)	10%	Not covered
8. Pediatric Services (under age 19)	Pediatric Dental Care - Preventive: Cleanings, Fluoride Treatment, Oral Exams - 2 per calendar year with a 3 rd cleaning covered with qualifying diagnosis Sealants - 1 per permanent molar every 5 calendar years X-ray - 1 set per calendar year	Covered in full	Not covered
	Pediatric Dental Care - Basic: Emergency / Palliative Treatment - emergency pain relief Endodontics - such as root canal Fillings (limitations apply) Oral Surgery - includes removal of teeth and surgical extractions	20%, deductible waived	Not covered

10 Essential Benefits (unless stated otherwise, a deductible applies)**What You Pay****In-Network****Out-of-Network**

Periodontal Maintenance - 2 per calendar year with a 3rd being covered with qualifying diagnosis
Scaling and Root Planing - 1 per 2 calendar years

Pediatric Dental Care - Major: Crowns, Inlays and Onlays - covered with limitations
Dentures (full or partial), Bridges (fixed partial denture) - repairs, rebase and relines covered with limitations

50%, deductible waived

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)

Not covered

Frames - limited to Otis & Piper Eyewear Collection

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)

\$4 retail prescription* / \$12 home delivery prescription

Preferred Brand-Name[†]

20% retail prescription / 20% home delivery prescription

Brand-Name

50% retail prescription / 50% home delivery prescription

Specialty

50% participating retail prescription

[†]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: \$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

10% 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)

\$10 copay per visit, deductible waived

Not covered

Spinal Manipulations (20 visits per calendar year)

\$10 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)

\$10 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.

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.

Value-Added Services

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

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, koji' 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 ដោយមិនគិតល្អិត គឺអាចមានសំរាប់អ្នក។ 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 (टिटाइप: 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)

ប្រៃសណីយ៍: ថ្នាំថា វាមានជាភាសា ខ្មែរ, ការបំរើការងារឆ្លើយតបភាសា, ដោយឥតគិតថ្លៃ, ដល់អ្នកប្រើប្រាស់។ ហៅ 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 711 TTY)