Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the BlueCross and BlueShield Association

Endorsement to Your Medical Policy or Booklet

This Endorsement modifies Your medical Policy or Booklet, effective March 25, 2020, pursuant to Proclamation 20-29 issued by the Governor of the State of Washington and to Emergency Orders 20-01, 20-02, and 20-04 issued by the Office of Insurance Commissioner of the State of Washington.

This Endorsement is subject to the provisions, terms, conditions, limitations and exclusions set forth in the Policy or Booklet to which it is attached. If there is any inconsistency between this Endorsement and the Policy or Booklet, the terms of this Endorsement will prevail.

The following changes are made to Your Policy or Booklet:

1. Deductibles, Copayments, and Coinsurance will be waived for the FDA-authorized COVID-19 test and the associated Provider visit.

2. Any prior authorization requirements that previously may have applied to covered testing and treatment for COVID-19 illness will be suspended.

3. While You should use In-Network Providers whenever possible, COVID-19 associated Covered Services from Out-of-Network Providers will be covered at the In-Network cost sharing level for those COVID-19 associated Covered Services.

4. A one-time early refill of covered Prescription Medications prior to the expiration of the waiting time between refills will be allowed, taking into account patient safety risks associated with certain drug classes. This one-time early refill does not apply to opioid medications.

5. Benefits will be extended to permit the use of a non-HIPAA compliant platform for the provision of Covered Services by In-Network Providers through telehealth. Any requirement for a secure HIPAA-compliant platform will be suspended for In-Network Providers that do not already utilize or are unable to readily access a HIPAA-compliant platform.

6. Deductibles, Copayments, and Coinsurance will be waived for diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), when such testing is determined to be medically necessary by Your Provider, and when billed in conjunction with a COVID-19 related diagnosis code.

7. Services provided at a drive-through site established for testing and assessment of COVID-19 are covered as a Provider visit when provided by In-Network Providers. The testing and assessment of COVID-19 symptoms performed at a drive-through site must be approved by either the U.S. Food and Drug Administration (FDA) or the Washington State Department of Health, and must be provided as ordered by Your Provider.

8. Any prior authorization requirements that may apply to long-term care facility or home health services following discharge from a Hospital will be suspended, when insufficient time exists to receive prior authorization before the delivery of care. Prior authorization for any other Covered Services necessary for discharge to a long-term care facility or home will be administered as an expedited prior authorization request.

9. The grace period for payment of monthly premiums is changed from 30 days to 60 days unless You are covered by a qualified health plan and receiving advanced premium tax credit through the Health Benefit Exchange. If monthly premium is not received within 60 days of the Premium Due Date (the grace period), coverage may end automatically and without further prior written notice on the thirty-

first day of the grace period, subject to Your continued obligation to pay premiums for the first thirty days of the grace period, and You potentially will be subject to billing from health care providers for unpaid claims for services rendered after the first thirty days of the grace period.

10. The amount which We reimburse an In-Network Provider furnishing a Medically Necessary Covered Service through telehealth will be the same as if the service was provided in person by the Provider.

Regence BlueShield complies with all state and federal requirements regarding COVID-19. The changes to Your Policy or Booklet outlined by this endorsement will remain in effect until the underlying Proclamation or Emergency Order expires without extension, is rescinded, or is further modified by the Governor of the State of Washington or the Office of Insurance Commissioner of the State of Washington.

For more information, call Customer Service at the number listed in Your Policy or Booklet or visit **regence.com**.

All other terms and conditions of Your Policy or Booklet remain unchanged.

IN WITNESS WHEREOF, We, by Our duly authorized officer, have executed this Endorsement.

Tim Lieb
President
Regence BlueShield

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com/go/2021/policy/WW/BronzeEssential7500EPOIFN or call 1 (888) 344-6347. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 344-6347 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$7,500 individual / $15,000 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8,550 individual / $17,100 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/WW/IFN or call 1 (888) 344-6347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$60 copay / office visit, deductible does not apply; 10% coinsurance for all other services	Not covered	Coverage includes primary care visits at a retail clinic. 4 in-network upfront office visits / year Copayment applies to each in-network upfront office visit (this limit is combined with in-network specialist and urgent care visits) and each in-network retail clinic visit only. Once the upfront visit limit is met, services are covered at the coinsurance specified, after deductible. Retail clinic visits do not apply to upfront visit limit.
	Specialist visit	$60 copay / office visit, deductible does not apply; 10% coinsurance for all other services	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2021/WW/6tier	Preferred generic drugs & generic drugs	$15 copay / preferred generic retail prescription $30 copay / preferred generic mail order prescription 10% coinsurance / generic retail prescription 5% coinsurance / generic mail order prescription	Not covered	No coverage for prescription drugs not on the Drug List. Deductible does not apply for insulin, covered diabetic supplies, preferred generic drugs, generic drugs and drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List. 90-day supply / retail prescription (your cost share is per 30-day supply) 90-day supply / mail order prescription 30-day supply / specialty drug retail prescription Cost shares for insulin will not exceed $100 / 30-day supply retail prescription or $300 / 90-day supply mail order prescription. If the deductible is not met, your cost share will also be applied to the deductible. Specialty drugs are not available through mail order.
	Preferred brand drugs	20% coinsurance / retail prescription 15% coinsurance / mail order prescription	Not covered	
	Brand drugs	50% coinsurance / retail prescription 45% coinsurance / mail	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		order prescription		No charge for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Preferred specialty drugs & specialty drugs	40% coinsurance / preferred specialty drugs 50% coinsurance / specialty drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.		None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	Not covered	None
	Inpatient services	10% coinsurance	Not covered	None
If you are pregnant	Office visits	10% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	130 visits / year
	Rehabilitation services	10% coinsurance	Not covered	30 inpatient days / year 25 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	10% coinsurance	Not covered	30 inpatient habilitative days / year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				25 outpatient habilitative visits / year 25 outpatient neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	10% coinsurance	Not covered	60 inpatient days / year
	Durable medical equipment	10% coinsurance	Not covered	None
	Hospice services	10% coinsurance	Not covered	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	No charge for VSP doctor	Not covered	1 routine eye examination / year for individuals under age 19.
	Children's glasses	No charge* for VSP doctor	Not covered	1 pair of lenses / year 1 set of frames / year Glasses limited to individuals under age 19. *Frames limited to Otis & Piper Eyewear Collection.
	Children's dental check-up	No charge	Not covered	2 cleanings* / year 2 preventive oral examinations / year Coverage limited to individuals under age 19. *Coverage may include another cleaning, refer to your plan for further information. Coverage includes basic and major dental services for individuals under age 19, refer to your plan for further information.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetic patients
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 344-6347. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (888) 344-6347 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Office of the Insurance Commissioner of Washington State by calling 1 (800) 562-6900, or through the Internet at: www.insurance.wa.gov.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1 (888) 344-6347.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$7,500**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,500
Copayments	$11
Coinsurance	$472
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$8,044**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$7,500**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$877
Copayments	$499
Coinsurance	$625
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$2,179**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$7,500**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,090
Copayments	$425
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,515**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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)