Regence Silver HSA Embedded 3000

Preferred

Effective January 1, 2021 through December 31, 2021

Regence

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 Deductible	The total deductible you pay per calendar year	$3,000 Individual $6,000 Family	$5,000 Individual $10,000 Family
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	$5,500 Individual $11,000 Family	$10,000 Individual $20,000 Family

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.

The In-Network Out-of-Pocket Maximum for any Member on Family Coverage is not to exceed $5,500, including the In-Network Deductible. If a Member reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, including the In-Network Deductible, benefits will be paid at 100% of the Allowed Amount for that Member.

Be aware that your actual costs for covered services provided by an Out-of-Network provider may exceed the Out-of-Pocket Maximum amount. In addition, Out-of-Network providers can bill you for the difference between the amount charged and our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum.

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
		In-Network	Out-of-Network
Primary Care Visits (for Illness or Injury)		20%	50%
Specialist Visits		20%	50%
Urgent Care Visits		20%	50%
Other Professional Services		20%	50%
Preventive Care/Immunizations		No charge	50%
Radiology and Laboratory - Outpatient		20%	50%
Complex Imaging - Outpatient	CT/PET/SPECT scans, MRIs, MRAs, etc.	20%	50%
Acupuncture and Chiropractic Spinal Manipulations	$1,000 limit for all services combined	20%	50%
Ambulance Services		20%	
Ambulatory Surgical Center		10%	50%
Biofeedback	10 visits per lifetime	20%	50%
Emergency Room (Including Professional Charges)		20%	
Employee Assistance Program (EAP)	4 mental health counseling visits per issue	No charge	Not covered
Home Health Care		20%	50%
Hospice Care	5 consecutive days of respite care, with a maximum of 30 days per lifetime	20%	50%
Hospital Care - Inpatient	$3,500 per day for inpatient non-emergency admissions to out-of-network facilities	20%	50%
Hospital Care - Outpatient		20%	50%
Mental Health/Substance Use Disorder - Inpatient	$3,500 per day for inpatient non-emergency admissions to out-of-network facilities	20%	50%
Mental Health/Substance Use Disorder - Outpatient		20%	50%
Palliative Care	30 visits per calendar year	20%	50%

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
		In-Network	Out-of-Network
Rehabilitation Services - Inpatient	30 days per year (up to 60 days for head or spinal cord) $3,500 per day for inpatient non-emergency admissions to out-of-network facilities	20%	50%
Rehabilitation Services - Outpatient	30 visits per calendar year	20%	50%
Reproductive Health Care Services		0%	50%
Retail Office Visits	Visits to a walk-in clinic located within a retail operation	20%	50%
Skilled Nursing Facility (SNF) Care	60 days per calendar year	20%	50%
Virtual Care - Store & Forward	Asynchronous (not real-time) communications such as text or fax	20%	50%
Virtual Care - Telehealth	Doctor visits via phone or video chat when not in a healthcare facility	20%	50%
Virtual Care - Telemedicine	Doctor visits via phone or video chat when in a healthcare facility	20%	50%

Pediatric Benefits - Dependents Under Age 19 (unless stated otherwise, a deductible applies)		What You Pay	
		In-Network	Out-of-Network
Dental Care - Preventive	Cleanings, Oral Exams, Fluoride Treatment - 2 per calendar year X-rays - 1 set per calendar year Sealants - 1 per molar every 5 calendar years	0%, deductible waived	
Dental Care - Basic	Fillings (limitations apply) Oral Surgery - includes removal of teeth and surgical extractions Emergency/Palliative Treatment - emergency pain relief Periodontal Maintenance - 2 per calendar year Scaling and root planing - 1 per 2 calendar years Endodontics - such as root canal	20%, deductible waived	
Dental Care - Major	Crowns, Inlays, Onlays - covered with limitations Dentures (Full or Partial), Bridges (fixed partial denture) - repairs, rebase, and relines covered with limitations	50%, deductible waived	
Vision Care	Exams - 1 complete eye exam per calendar year Lenses - 1 pair of standard lenses per calendar year; includes scratch and UV protection Frames - 1 frame per calendar year Contacts - available once per year in lieu of all other lenses/frame benefits	$0, deductible waived Frames - limited to Otis & Piper Eyewear collection	50%, deductible waived
	Find your vision plan benefits or a VSP vision provider at regence.com or call 1 (844) 299-3041		

Prescription Medication Benefits (unless stated otherwise, a deductible applies)		What You Pay
Annual Deductible	The total deductible you pay per calendar year	Shared with medical
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with medical
Preferred Generic†	90-day supply for retail or mail order	10% retail prescription / 5% mail order prescription
Generic	90-day supply for retail or mail order	25% retail prescription / 20% mail order prescription
Preferred Brand†^	90-day supply for retail or mail order	35% retail prescription / 30% mail order prescription
Brand	90-day supply for retail or mail order	50% retail prescription / 45% mail order prescription
Preferred Specialty	30-day supply for retail	20% participating pharmacy retail prescription

Prescription Medication Benefits (unless stated otherwise, a deductible applies)		What You Pay
Specialty	30-day supply for retail	50% participating pharmacy retail prescription

†Deductible waived on retail prescriptions for medications on the Optimum Value Medication List (OVML) located on our website
^$100 cap on member cost share per 30 day retail supply insulin, deductible waived
^$200 cap on member cost share for up to 90 day supply of mail order insulin, deductible waived
20% for each self-administered Cancer Chemotherapy medication
More information about prescription drug coverage is available at https://regence.com/go/2021/OR/6tier

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 regence.com.
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.

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 booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET 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. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

1 (888) 367-2116 - 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'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)