# Regence Bronze Essential 8500 Legacy

*Clark County*

***Effective January 1, 2027 through December 31, 2027***

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 | $8,500 Individual<br>$17,000 Family | Not covered |
| Annual Prescription Deductible | The total deductible You pay per Calendar Year for prescription medications | Shared with medical | Not covered |
| Annual Out-of-Pocket Maximum | The combined total for Your deductible(s), coinsurance and copays per Calendar Year | $10,500 Individual<br>$21,000 Family | Not covered |

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 and Out-of-Network pharmacies 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) | 4 visit upfront benefit for Primary Care, Specialist and Urgent Care visits combined | First 4 visits, $40 copay per visit, deductible waived | Not covered |
| Specialist Visits | | After first 4 visits, 30% coinsurance, after deductible | Not covered |
| Urgent Care Visits | | | Not covered |
| Other Professional Services | | 30% | Not covered |
| Preventive Care / Immunizations | Wellness Rewards available | Covered in full | Not covered |
| Radiology and Laboratory - Outpatient | | 30% | Not covered |
| Complex Imaging - Outpatient | CT / PET / SPECT scans, MRIs, MRAs, etc. | 30% | Not covered |
| Acupuncture | | 30% | Not covered |
| Ambulance Services | Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment | 30% | |
| Ambulatory Surgical Center | | 20% | Not covered |
| Emergency Room | Facility and professional services | 30% | |
| Hearing Instruments and Services | One hearing instrument per ear with hearing loss every 36 months, including bone conduction hearing devices.<br>Excludes: over-the-counter hearing aids, routine hearing examinations, batteries and cords, and assistive listening devices | Covered in full | Not covered |
| Hospital Care - Inpatient | | 30% | Not covered |
| Hospital Care - Outpatient | See Ambulatory Surgical Center for cost reduction option | 30% | Not covered |
| Mental Health / Substance Use Disorder - Inpatient | | 30% | Not covered |
| Mental Health / Substance Use Disorder - Outpatient | In addition to this benefit, see Employee Assistance Program (EAP) option | 30% | Not covered |
| Rehabilitation Services - Inpatient | 30 days per Calendar Year | 30% | Not covered |
| Rehabilitation Services - Outpatient | 25 visits per Calendar Year | 30% | Not covered |
| Skilled Nursing Facility | 60 days per Calendar Year | 30% | Not covered |
| Spinal Manipulations | 10 spinal manipulation visits per Calendar Year | 30% | Not covered |
| Virtual Care - Telehealth | Doctor visits via phone or video chat when not in a healthcare facility (includes Mental Health visits) | Covered in full | Not covered |

| Pediatric Benefits - Dependents Under Age 19 (*unless stated otherwise, a deductible applies*) | | What You Pay | |
|---|---|---|---|
| | | In-Network | Out-of-Network |
| Dental Care - Preventive (Pediatric) | Cleanings - 2 per Calendar Year, additional covered with qualifying diagnosis<br>Fluoride Treatment - topical fluoride application when dentally appropriate<br>Oral Exams - 2 per Calendar Year<br>Sealants - when dentally appropriate<br>Silver Diamine Fluoride - 2 per tooth per Calendar Year<br>X-rays | Covered in full | Not covered |
| Dental Care - Basic (Pediatric) | Emergency / Palliative Treatment - emergency pain relief<br>Endodontics - such as root canal<br>Fillings (limitations apply)<br>Oral Surgery - includes removal of teeth and surgical extractions<br>Periodontal Maintenance - 1 per quadrant per Calendar Year<br>Scaling and Root Planing - once per quadrant in a 2-year period | 20%, deductible waived | Not covered |
| Dental Care - Major (Pediatric) | Crowns, Inlays and Onlays - covered with limitations<br>Dentures (full or partial), Bridges (fixed partial denture) - repairs, rebase, and relines covered with limitations | 50%, deductible waived | Not covered |
| Dental4Health Program | Members with certain medical diagnoses may be eligible for additional Dental Services benefits at no extra cost. To learn more about eligibility and Covered Services, visit https://regencedental.com/members/Dental4Health or refer to Your Benefit Book. | | |
| Vision Care (Pediatric) | Exam - 1 comprehensive routine eye exam per Calendar Year<br>Contacts - available once per Calendar Year in lieu of all other lenses / frame benefits<br>Frames - 1 frame per Calendar Year<br>Lenses - 1 pair of standard lenses per Calendar Year; includes scratch and UV protection | Covered in full (for routine exam and hardware)<br>Frames - limited to Otis & Piper Eyewear Collection | Not covered |
| | Find Your vision plan benefits or a VSP vision Doctor at regence.com or call 1-844-299-3041 | | |

| Prescription Medication Benefits (*unless stated otherwise, a deductible applies*) | | What You Pay | |
|---|---|---|---|
| | | In-Network | Out-of-Network |
| Preferred Generic | Deductible waived<br>90-day supply for retail or home delivery | $10 retail prescription* / $30 home delivery prescription | Not covered |
| Generic | Deductible waived<br>90-day supply for retail or home delivery | $35 retail prescription* / $105 home delivery prescription | Not covered |
| Preferred Brand-Name | 90-day supply for retail or home delivery | 25% retail prescription / 25% home delivery prescription | Not covered |
| Brand-Name | 90-day supply for retail or home delivery | 50% retail prescription / 50% home delivery prescription | Not covered |
| Preferred Specialty | 30-day supply for retail | 20% specialty drug | Not covered |
| Specialty | 30-day supply for retail | 50% specialty drug | Not covered |

**1 copay per 30-day supply*
***Cost Shares** for insulin, certain inhaled asthma medications and epinephrine autoinjectors (per 2 pack) will not exceed $35 per 30-day supply, deductible waived; or $105 per 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/2027/CC/6tier*

## 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.

| | |
|---|---|
| Employee Assistance Program (EAP) | EAP is short-term, confidential counseling with no out-of-pocket expense. (4 mental health counseling visits per issue) |
| Joint, Spine, and Muscle Program | The Joint, Spine, and Muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles. |
| 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. |
| Regence Advantages | Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. |
| Well-Being Program | The Well-Being Program offers a range of tools, information and support for a healthy lifestyle.<br>Wellness Rewards available. |

## Provider Networks

**Your enrolled network is Legacy**. To find Providers in Your network, please sign into Your account and use Our Provider search tool: https://regence.com/go/CC/Legacy.

## Out-of-Area Services

Outside of the service area, Members have In-Network benefits for Ambulance and Emergency Room only, in addition to prior approved Out-of-Network coverage. Additionally, Members will receive In-Network benefits for Ambulance and Emergency Room at Blue Cross and / or Blue Shield (Blue Plan) facilities across the country through the BlueCard® Program and worldwide through the Blue Cross Blue Shield 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 regence.com. |
| Is there a cost for "Covered in full"? | No, if Your benefit is covered in full, there is no copay or deductible. |
| 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.

Customer Service: 1-888-367-2116 - TTY: 711 | 200 SW Market Street 11th Floor, Portland, OR 97201 | regence.com

# NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

**Regence:**
**Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:**

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

**Provides free language assistance services to people whose primary language is not English, which may include:**

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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, sex, sexual orientation or gender identity, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

**Customer Service**
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

**Medicare Customer Service**
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

**VSP Customer Service**
Phone: 1-844-299-3041, (TTY: 711)

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, available 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

## 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' hódíilnih 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)