Regence Silver 3500 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	$3,500 Individual $7,000 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	$10,150 Individual $20,300 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)		$40 copay per visit, deductible waived	Not covered
Specialist Visits		$60 copay per visit, deductible waived	Not covered
Urgent Care Visits		$60 copay per visit, deductible waived	Not covered
Other Professional Services		35%	Not covered
Preventive Care / Immunizations	Wellness Rewards available	Covered in full	Not covered
Radiology and Laboratory - Outpatient		35%	Not covered
Complex Imaging - Outpatient	CT / PET / SPECT scans, MRIs, MRAs, etc.	35%	Not covered
Acupuncture		$40 copay per visit, deductible waived	Not covered
Ambulance Services	Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment	35%	Not covered
Ambulatory Surgical Center		25%	Not covered
Emergency Room	Facility and professional services	After $400 copay per visit and deductible, then 35%	
Hearing Instruments and Services	One hearing instrument per ear with hearing loss every 36 months, including bone conduction hearing devices. Excludes: over-the-counter hearing aids, routine hearing examinations, batteries and cords, and assistive listening devices	Covered in full	Not covered
Hospital Care - Inpatient		35%	Not covered
Hospital Care - Outpatient	See Ambulatory Surgical Center for cost reduction option	35%	Not covered
Mental Health / Substance Use Disorder - Inpatient		35%	Not covered
Mental Health / Substance Use Disorder - Outpatient	In addition to this benefit, see Employee Assistance Program (EAP) option	$40 copay per outpatient office / psychotherapy visit, deductible waived Other Outpatient services 35%	Not covered
Rehabilitation Services - Inpatient	30 days per Calendar Year	35%	Not covered
Rehabilitation Services - Outpatient	25 visits per Calendar Year	$40 copay per visit, deductible waived	Not covered

Medical Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
Skilled Nursing Facility	60 days per Calendar Year	35%	Not covered
Spinal Manipulations	10 spinal manipulation 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 Mental Health visits)	$10 copay per visit, deductible waived	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 Fluoride Treatment - topical fluoride application when dentally appropriate Oral Exams - 2 per Calendar Year Sealants - when dentally appropriate Silver Diamine Fluoride - 2 per tooth per Calendar Year X-rays	Covered in full	Not covered
Dental Care - Basic (Pediatric)	Emergency / Palliative Treatment - emergency pain relief Endodontics - such as root canal Fillings (limitations apply) Oral Surgery - includes removal of teeth and surgical extractions Periodontal Maintenance - 1 per quadrant per Calendar Year 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 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 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	Covered in full (for routine exam and hardware) 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 90-day supply for retail or home delivery	$20 retail prescription* / $60 home delivery prescription	Not covered
Generic	Deductible waived 90-day supply for retail or home delivery	$35 retail prescription* / $105 home delivery prescription	Not covered
Preferred Brand-Name	Deductible waived 90-day supply for retail or home delivery	$60 retail prescription* / $180 home delivery prescription	Not covered
Brand-Name	Deductible waived 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

Prescription Medication Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
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*
35% 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. 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)