Regence Platinum 250

Preferred

Effective January 1, 2024 through December 31, 2024

Regence

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	$250 Individual $500 Family	$3,000 Individual $6,000 Family
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	$4,000 Individual $8,000 Family	$10,000 Individual $20,000 Family

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)		First 3 Primary Care, Behavioral Health and Virtual Care visits combined, $5 copay per visit, deductible waived After 3 visits, $20 copay per visit, deductible waived	50%
Specialist Visits		$30 copay per visit, deductible waived	50%
Urgent Care Visits		$30 copay per visit, deductible waived	50%
Other Professional Services		10%	50%
Preventive Care / Immunizations	Preventive Employee Wellness Incentives available	Covered in full	50%
Radiology and Laboratory - Outpatient		10%, deductible waived	50%
Complex Imaging - Outpatient	CT / PET / SPECT scans, MRIs, MRAs, etc.	10%	50%
Acupuncture	12 visits per calendar year	$20 copay per visit, deductible waived	50%
Ambulance Services	Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment	10%, In-Network deductible applies	
Ambulatory Surgical Center		5%	50%
Behavioral Health Services - Inpatient	$3,500 per day for inpatient non-emergency admissions to Out-of-Network facilities	10%	50%
Behavioral Health Services - Outpatient	In addition to this benefit, see Employee Assistance Program option	First 3 Primary Care, Behavioral Health and Virtual Care visits combined, $5 copay per visit, deductible waived After 3 visits, $20 copay per outpatient office / psychotherapy visit, deductible waived	50%
Emergency Room	Facility and professional services	$250 copay per visit, In-Network deductible applies	
Hearing Aids, Cochlear Implants and Assistive Listening Devices	1 hearing aid per ear every 36 months Excludes over-the-counter hearing aids, routine hearing exams, television caption decoder and cords	10%, deductible waived	50%, deductible waived

Medical Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
Hospital Care - Inpatient	$3,500 per day for inpatient non-emergency admissions to Out-of-Network facilities	10%	50%
Hospital Care - Outpatient	See Ambulatory Surgical Center for cost reduction option	10%	50%
Rehabilitation Services - Inpatient	30 days per calendar year (up to 60 days for head or spinal cord injury) $3,500 per day for inpatient non-emergency admissions to Out-of-Network facilities	10%	50%
Rehabilitation Services - Outpatient	30 visits per calendar year	$20 copay per visit, deductible waived	50%
Skilled Nursing Facility	60 days per calendar year	10%	50%
Spinal Manipulations	20 visits per calendar year	$20 copay per visit, deductible waived	50%
Virtual Care - Telehealth	Doctor visits via phone or video chat when not in a healthcare facility (includes Behavioral Health visits)	First 3 Primary Care, Behavioral Health and Virtual Care visits combined, $5 copay per visit, deductible waived After 3 visits, $10 copay per visit, deductible waived	50%

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, Oral Exams - 2 per calendar year Sealants - 1 per permanent molar every 5 calendar years X-rays - 1 set per calendar year	Covered in full	
Dental Care - Basic (Pediatric)	Emergency / Palliative Treatment - emergency pain relief Endodontics - such as root canal Fillings - composite and amalgam restorations Oral Surgery - includes removal of teeth and surgical extractions Periodontal Maintenance - 2 per calendar year Scaling and Root Planing - 1 per 2 calendar years	20%, deductible waived	
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	
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 Find Your vision plan benefits or a VSP vision provider at regence.com or call 1 (844) 299-3041	$0 copay, deductible waived (for routine exam and hardware) Frames - limited to Otis & Piper Eyewear Collection	50%, deductible waived (for routine exam and hardware) Frames - no restrictions on frame selection

Prescription Medication Benefits (*unless stated otherwise, a deductible applies*)		What You Pay
Preferred Generic	Deductible waived 90-day supply for retail or home delivery	$8 retail prescription* / $24 home delivery prescription
Generic	Deductible waived 90-day supply for retail or home delivery	$35 retail prescription* / $105 home delivery prescription
Preferred Brand-Name	Deductible waived 90-day supply for retail or home delivery	$30 retail prescription* / $90 home delivery prescription

Prescription Medication Benefits (*unless stated otherwise, a deductible applies*)		What You Pay
Brand-Name	Deductible waived 90-day supply for retail or home delivery	50% retail prescription / 50% home delivery prescription
Preferred Specialty	Deductible waived 30-day supply for retail	20% participating pharmacy retail prescription
Specialty	Deductible waived 30-day supply for retail	50% participating pharmacy retail prescription

**1 copay per 30-day supply*
Insulin Cost Share Cap: *Retail or home delivery: $85 cap on Member cost share per 30-day supply, deductible waived; $255 cap on Member 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/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)
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.
Regence Empower	Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. Preventive Employee Wellness Incentives are available.

Out-of-Area Services

Outside of the service area, Members have In-Network benefits 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.

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