



# Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association



## Special Districts Insurance Services

### SDIS Red H Plan

Effective July 1, 2024 through June 30, 2025

Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per calendar year	\$2,000 Individual \$4,000 Family	
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	\$5,500 Individual \$14,700 Family	\$7,000 Individual

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	
Primary Care Visits (for Illness or Injury)	First 3 upfront visits combined for primary care and behavioral health services.	\$5 copay, deductible waived/ first 3 visits	50% coinsurance
Specialist Visits		\$35 copay per visit, after 3 upfront visits, deductible waived	50% coinsurance
Urgent Care Visits		\$35 copay per visit, deductible waived	50% coinsurance
Other Professional Services		30% coinsurance	50% coinsurance
Preventive Care/Immunizations	<ul style="list-style-type: none"> <li>Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA)</li> </ul>	0% coinsurance, deductible waived	50% coinsurance
Acupuncture	<ul style="list-style-type: none"> <li>Limit: 30 visits per Calendar year</li> </ul>	\$35 copay per visit, deductible waived	50% coinsurance
Ambulance Services		0% coinsurance, deductible waived	0% coinsurance, deductible waived
Ambulatory Surgical Center		30% coinsurance	50% coinsurance
Emergency Room (Including Professional Charges)		30% coinsurance after \$250 copay per visit; deductible waived	30% coinsurance after \$250 copay per visit; deductible waived
Hearing Aids & Evaluations	<ul style="list-style-type: none"> <li>1 hearing aid per ear, every calendar year</li> </ul>	30% coinsurance	50% coinsurance
Hearing Examinations	<ul style="list-style-type: none"> <li>Limit: 1 exam per Calendar year</li> </ul>	\$35 copay per visit, deductible waived	50% coinsurance
Home Health Care	<ul style="list-style-type: none"> <li>Limit: 130 visits per Calendar year</li> </ul>	30% coinsurance	50% coinsurance
Hospice Care	<ul style="list-style-type: none"> <li>Limit: 30 inpatient or outpatient respite care days per lifetime</li> </ul>	30% coinsurance	50% coinsurance
Hospital Care		30% coinsurance	50% coinsurance
Massage Therapy	<ul style="list-style-type: none"> <li>Limit: 12 visits per Calendar year</li> <li>Licensed Massage Therapists only</li> </ul>	\$35 copay per visit, deductible waived	50% coinsurance
Maternity Care		30% coinsurance	50% coinsurance
Behavioral Health - Inpatient	<ul style="list-style-type: none"> <li>Mental health, behavioral health, or substance abuse services</li> </ul>	30% coinsurance	50% coinsurance

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
Behavioral Health - Outpatient	First 3 upfront visits combined for primary care and behavioral health services.	\$5 copay, deductible waived/ first 3 visits	50% coinsurance
	<ul style="list-style-type: none"> <li>Mental health, behavioral health, or substance abuse services</li> </ul>	\$35 copay per visit, after 3 upfront visits, deductible waived	
Neurodevelopmental Therapy	<ul style="list-style-type: none"> <li>Limit: 30 visits per Calendar year</li> <li>Children up to the age of 18</li> </ul>	30% coinsurance, deductible waived	50% coinsurance
Newborn Home Visits	<ul style="list-style-type: none"> <li>Within 6 months of age, at least one visit during first 3 months, with up to 3 more available</li> </ul>	0%, deductible waived	Not covered
Nutritional Counseling	<ul style="list-style-type: none"> <li>Limit: 5 visits per lifetime</li> </ul>	30% coinsurance	50% coinsurance
Radiology and Laboratory - Outpatient		30% coinsurance, deductible waived	50% coinsurance
Advanced Imaging	<ul style="list-style-type: none"> <li>CT, PET, MRA, SPECT, Bone Density, MRI</li> </ul>	30% coinsurance	50% coinsurance
Rehabilitation Services - Inpatient	<ul style="list-style-type: none"> <li>30 days per Calendar year</li> </ul>	30% coinsurance	50% coinsurance
Rehabilitation Services - Outpatient	<ul style="list-style-type: none"> <li>30 visits combined per Calendar year</li> </ul>	30% coinsurance, deductible waived	50% coinsurance
Skilled Nursing Facility (SNF) Care	<ul style="list-style-type: none"> <li>Limit: 60 days per Calendar year</li> </ul>	30% coinsurance	50% coinsurance
Spinal Manipulations	<ul style="list-style-type: none"> <li>Limit: 30 visits per Calendar year</li> </ul>	\$35 copay per visit, deductible waived	50% coinsurance
Virtual Care - Telehealth		<b>Vendor: MDLive</b>	N/A
		\$0 copay per session, deductible waived	
		<b>In-Network non-Vendor Provider:</b>	50% coinsurance
		\$0 copay per visit, deductible waived	

VSP Vision Benefits		What You Pay	
Routine Eye Exam	<ul style="list-style-type: none"> <li>Limit: 1 per Calendar year</li> </ul>	\$35 copay, deductible waived	No charge up to \$45
Contact Lens Fitting	<ul style="list-style-type: none"> <li>Limit: 1 per Calendar year</li> </ul>	No charge	Applies to the hardware limit
Hardware		No charge up to \$250 maximum per year	No charge up to \$250 maximum per year

Prescription Medication Benefits		What You Pay	
Annual Deductible	The total deductible you pay per calendar year	\$0	
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with medical	
Tier 1	30-day supply for retail, 90-day supply for mail order	\$10 retail prescription / \$10 mail order prescription / \$10 for each self-administrable Cancer Chemotherapy medication	
Tier 2	30-day supply for retail, 90-day supply for mail order	\$30 retail prescription / \$60 mail order prescription / \$50 for each self-administrable Cancer Chemotherapy medication	
Tier 3	30-day supply for retail, 90-day supply for mail order	\$50 retail prescription / \$100 mail order prescription / \$100 for each self-administrable Cancer Chemotherapy medication	
Tier 4	30-day supply for retail	30% Coinsurance to \$200 maximum per prescription	
Compound Medications	30-day supply for retail	50% coinsurance	

\$85 cap on member cost share per 30 day retail supply insulin, deductible waived  
\$255 cap on member cost share for up to 90 day supply of mail order insulin, deductible waived  
More information about prescription drug coverage is available at <https://regence.com/go/2023/OR/4tier>

## 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 <a href="https://www.regence.com">regence.com</a> .
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](https://www.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 (866) 240-9580 - TTY: 711 | 100 SW Market Street, Portland, OR 97201 | [regence.com](https://www.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@regencecom

#### **Customer Service for all other plans**

Civil Rights Coordinator

MS CS B32B, PO Box 1271

Portland, OR 97207-1271

1-888-344-6347, (TTY: 711)

CS@regencecom

You can also file a civil rights complaint with the US 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:

US 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。

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jii'eh, 47 n1 h0l=, koj8' h0d77lnih 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 ដោយមិនគិតល្អល គឺអាចមានសំរាប់បម្រើអ្នក។ 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፣ በገጸ ሊያገለግሉት ተዘጋጅተዋል፤ 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)

ប្រគល់: បើសិនជា អ្នកនិយាយ ភាសា ខ្មែរ, ការបំរើការជំនួយផ្នែកភាសា, ដោយមិនគិតល្អល គឺអាចមានសំរាប់បម្រើអ្នក។ ចូរ ទូរស័ព្ទ 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 بہ 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 711)