Regence Silver 3200 EPO

UW Medicine

Effective January 1, 2020 through December 31, 2020

Regence

Regence BlueShield serves select counties in the state of Washington and 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	$3,200 Individual $6,400 Family	Not covered
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	$8,150 Individual $16,300 Family	Not covered
10 Essential Benefits (unless stated otherwise, a deductible applies)		**What You Pay**	
1. Ambulatory Care	Primary Care Visits (for illness or injury)	$30 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
2. Emergency Care	Emergency Room Care	30%	30%
	Ambulance	30%	30%
3. Hospitalization	Hospital Care - Inpatient	30%	Not covered
	Supplies	30%	Not covered
4. Radiology / Laboratory Services	Radiology / Laboratory - Inpatient	30%	Not covered
	Radiology / Laboratory - Outpatient	30%	Not covered
5. Maternity and Newborn Care	Maternity Care	30%	Not covered
6. Mental Health / Substance Use Disorder Services	Mental Health / Substance Use Disorder - Inpatient	30%	Not covered
	Mental Health / Substance Use Disorder - Outpatient	30%	Not covered
7. Rehabilitative / Habilitative Services	Habilitative - Inpatient (30 days per calendar year)	30%	Not covered
	Habilitative - Outpatient (25 visits per calendar year)	30%	Not covered
	Rehabilitative - Inpatient (30 days per calendar year)	30%	Not covered
	Rehabilitative - Outpatient (25 visits per calendar year)	30%	Not covered
8. Pediatric Services (up to age 19)	Preventive Dental Care	Covered in full	Not covered
	Vision Care	VSP doctors covered in full	Not covered
9. Prescription Medications	Preferred Generic (deductible waived)	$15* retail prescription / $30 mail order prescription	
	Generic (deductible waived)	25%* retail prescription / 20% mail order prescription	
	Preferred Brand	30%* retail prescription / 25% mail order prescription	
	Brand	50%* retail prescription / 45% mail order prescription	
	Preferred Specialty	40% participating retail prescription	
	Specialty	50% participating retail prescription	
**$5 copay or 5% coinsurance discount for non-specialty medications when filled at a preferred pharmacy. Your amount will not be lower than $0. 30% for each self-administered Cancer Chemotherapy medication*			
10. Preventive Services	Annual Physical Exams	Covered in full	Not covered
	Immunizations	Covered in full	Not covered
	Preventive Screenings	Covered in full	Not covered

10 Essential Benefits (unless stated otherwise, a deductible applies)		**What You Pay**	
Other Services	Acupuncture & Spinal Manipulation (12 Acupuncture and 10 Spinal Manipulation visits per year)	$30 copay per visit, deductible waived	Not covered
	Retail Office Visits (Visits to a walk-in clinic located within a retail operation)	$15 copay per visit, deductible waived	Not covered
	Virtual Care - Store and Forward (asynchronous [not real-time] communications such as text or fax)	Covered in full	Not covered
	Virtual Care - Telehealth (doctor visits via phone or video chat when not in a healthcare facility)	$10 copay per visit, deductible waived	Not covered

Available Networks

There are several provider networks in your state. Please note that these networks are not interchangeable and support different providers. **Your enrolled network is UW Medicine**. To find providers in your network, please sign into your account and use our provider search tool: regence.com/go/UWM.

Out-of-Area Services

Outside of the service area, members have In-Network benefits for Emergency Room and Ambulance care only. In addition, members will receive In-Network benefits at Blue Cross and/or Blue Shield (Blue Plan) Urgent Care facilities across the country through the BlueCard® Program and worldwide through the BlueCross BlueShield 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.

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/go/UWM.
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.

Definitions

Allowed amount: The lower price an in-network provider has agreed to accept as payment in full for the care provided to you.

Balance billing: The difference between the provider's charge and what your plan pays.

Coinsurance: Your share of the cost for care after you pay any deductible. It's usually a percentage of the total cost of care (for example, 20%).

Copay: A flat dollar amount you pay for care, like a doctor's visit, hospital outpatient visit or prescription. You'll usually pay it when you go in for care.

Deductible: The amount you pay out of your own pocket each calendar year before your plan begins to pay. Some services, such as preventive care, are sometimes covered at 100% before you've met your deductible.

Drug list (also known as a formulary): A list of prescription medications that your plan covers. It includes brand-name, generic and specialty drugs.

Exclusive provider organization networks (EPOs): EPOs cover only in-network care. This means you are responsible for 100 percent of the costs of any out-of-network care (excluding emergency services). To avoid surprise bills, you must be careful to always see an in-network provider.

Explanation of benefits (EOB): A statement that explains how much Regence paid toward a claim and how much you owe the provider for care.

Generic drugs: A prescription medication approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name version. Generally, a generic drug works the same as a brand-name drug and usually costs less.

In-Network provider: A facility or health professional contracted with your plan. You usually have lower out-of-pocket costs when you use in-network providers.

Out-of-Network provider: A facility or health professional not contracted with your plan. You usually have higher out-of-pocket costs when you use out-of-network providers.

Out-of-Pocket maximum: The most you'll have to pay in deductible, coinsurance and copays per calendar year. Once you've met this maximum, Regence pays 100% of your covered care for the rest of the calendar year.

Point of service (POS): A type of managed care health insurance that has the characteristics of an EPO with lean out-of-network coverage. It has a provider-focused network (known as a medical neighborhood) that lowers out of pocket costs and provides medical savings, while still enabling access to providers outside of the network, but with higher out-of-pocket costs.

Primary Care Provider (PCP): A doctor or other health professional you see as the first point of contact for medical care and your partner in managing your health care.

Specialist: An expert in a particular area of medicine, for example, a dermatologist, allergist or cardiologist.

Telehealth: Care that you receive from a doctor over the phone or computer for routine needs and ailments.

1 (888) 344-6347 - TTY: 711 | 1800 Ninth Avenue, Seattle, WA 98101 | 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)