Regence HSA Healthplan 3.0SM

Preferred

Regence BlueShield of Idaho, Inc.

Effective September 1, 2021 through August 31, 2022

Regence

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

Cost Share Details		In-Network	Out-of-Network
Coinsurance	The amount you pay after you meet your deductible	30%	50%
Annual Deductible	The total deductible you pay per calendar year	$2,500 Individual $5,000 Family	Shared with In-Network
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	$5,000 Individual $10,000 Family	Shared with In-Network

Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.

The In-Network Out-of-Pocket Maximum for any Member on Family Coverage is not to exceed $6,850, including the In-Network Deductible. If a Member reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, including the In-Network Deductible, benefits will be paid at 100% of the Allowed Amount for that Member.

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)		30%	50%
Specialist Visits		30%	50%
Urgent Care Visits		Covered the same as if you visit a health care provider's office or clinic (Primary Care Visit or Specialist Visit) or if you have a test (Radiology and Laboratory or Complex Imaging).	
Other Professional Services		30%	50%
Preventive Care/Immunizations		No charge	50%
Radiology and Laboratory - Inpatient		30%	50%
Radiology and Laboratory - Outpatient		30%	50%
Complex Imaging - Outpatient	CT/PET/SPECT scans, MRIs, MRAs, etc.	30%	50%
Ambulance Services		30%	
Ambulatory Surgical Center		20%	50%
Blood Bank		30%	
Dental Hospitalization		30%	50%
Detoxification		30%	50%
Diabetic Education		30%	50%
Durable Medical Equipment		30%	50%
Emergency Room (Including Professional Charges)		30%	
Gene Therapy and Adoptive Cellular Therapy	$7,500 limit per member (and companion(s)) combined for transportation, lodging and meal expenses per course of treatment Commercial lodging expenses are limited to $300 per night for the Member and companion(s) combined Meal expenses are limited to $80 per day per Member or per companion(s)	30%	90%
Genetic Testing		30%	50%

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
		In-Network	Out-of-Network
Home Health Care	130 visits per calendar year	30%	50%
Hospice Care	14 days of respite care per lifetime	30%	50%
Hospital Care		30%	50%
Maternity Care		30%	50%
Medical Foods		30%	50%
Mental Health/Substance Use Disorder	Applied behavioral analysis (ABA) for the treatment of autism spectrum disorders included	30%	50%
Neurodevelopmental Therapy - Outpatient	28 visits per calendar year Children age 6 and under	30%	50%
Newborn Care		30%	50%
Nutritional Counseling	3 visits per calendar year	30%	50%
Orthotic Devices		30%	50%
Palliative Care	30 visits per calendar year	30%	50%
Prosthetic Devices		30%	50%
Rehabilitation Services - Inpatient	22 days per calendar year	30%	50%
Rehabilitation Services - Outpatient	30 visits per calendar year	30%	50%
Repair of Teeth	Due to injury to sound natural teeth	30%	50%
Retail Clinic Office Visits (for Illness or Injury)	Professional services performed in a retail clinic, which are not considered or billed as an office visit	30%	50%
Skilled Nursing Facility (SNF) Care	60 days per calendar year	30%	50%
Spinal Manipulations	18 spinal manipulations per calendar year	30%	50%
Temporomandibular Joint (TMJ) Disorders		30%	50%
Termination of Pregnancy	When performed to preserve the life of the enrolled female individual	30%	50%
Transplants		30%	50%
Virtual Care - Telehealth	Doctor visits via phone or video chat when not in a healthcare facility	**Vendor:** 10% **In-Network non-Vendor Provider:** 30%	50%
Virtual Care - Telemedicine	Doctor visits via phone or video chat when in a healthcare facility	30%	50%

Prescription Medication Benefits (unless stated otherwise, a deductible applies)		What You Pay
Annual Deductible	The total deductible you pay per calendar year	Shared with medical
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with medical
Generic†	90-day supply for retail or mail order	30% retail prescription / 30% mail order prescription
Preferred Brand†^	90-day supply for retail or mail order	30% retail prescription / 30% mail order prescription
Brand	90-day supply for retail or mail order	30% retail prescription / 30% mail order prescription

Prescription Medication Benefits (unless stated otherwise, a deductible applies)		What You Pay
Specialty	30-day supply for retail	Refer to Generic, Preferred Brand and Brand above for participating pharmacy retail prescription / 90% nonparticipating pharmacy retail prescription

†Deductible waived on retail prescriptions for medications on the Optimum Value Medication List (OVML) located on our website
^$100 cap on member cost share per 30 day retail supply of insulin, deductible waived
^$300 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/2021/ID/3tier

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.
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.

General Exclusions

Activity Therapy: The following activity therapy services are not covered: creative arts, play, dance, aroma, music, equine or other animal-assisted, recreational or similar therapy, and sensory movement groups.

Acupuncture

Adventure, Outdoor, or Wilderness Interventions and Camps: Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to, interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;
- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:
  - blindness;
  - deafness/hardness of hearing;
  - a Mental Health Condition; or
  - a Substance Use Disorder.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service in this Booklet.

Assisted Reproductive Technologies: Assisted reproductive technologies, regardless of underlying condition or circumstance, are not covered, including, but not limited to: cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception; or any associated surgery, medications, testing or supplies.

Certain Therapy, Counseling and Training: Except as provided in the Employee Assistance Program (EAP) Section, if applicable, the following therapies, counseling and training services are not covered: educational, vocational, social, image, self-esteem, milieu or marathon group therapy, premarital or marital counseling, EAP services, and job skills or sensitivity training.

Conditions Caused by Active Participation in a War or Insurrection: The treatment of any condition caused by or arising out of a Member's active participation in a war or insurrection.

Conditions Incurred in or Aggravated During Performances in the Uniformed Services: The treatment of any Member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Cosmetic/Reconstructive Services and Supplies: Except for treatment of the following, cosmetic and/or reconstructive services and supplies are not covered:

- a Congenital Anomaly;
- to restore a physical bodily function lost as a result of Illness or Injury; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

"Cosmetic" means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

"Reconstructive" means services, procedures or surgery performed on abnormal structures of the body, caused by Congenital Anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Counseling in the Absence of Illness: Except as required by law, counseling in the absence of Illness is not covered.

Custodial Care: Except as provided in the Palliative Care benefit, non-skilled care and helping with activities of daily living is not covered.

Dental Services: Except as provided in the Repair of Teeth benefit, Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

Elective Abortion: Except when performed to preserve the life of the enrolled female Member, termination of pregnancy (elective abortion) is not covered.

Expenses Before Coverage Begins or After Coverage Ends: Services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

Family Counseling: Except when provided as part of the treatment for a child or adolescent with a covered diagnosis, family counseling is not covered.

General Exclusions

Fees, Taxes, Interest: Except as required by law, the following fees, taxes and interest are not covered: charges for shipping and handling, postage, interest or finance charges that a Provider might bill; excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity.

Government Programs: Except as required by state law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with Us, benefits that are covered (or would be covered in the absence of this plan) by any federal, state or government program are not covered.

Additionally, except as listed below, government facilities or government facilities outside the service area are not covered:

- facilities contracting with the local Blue Cross and/or Blue Shield plan; or
- as required by law for emergency services.

Growth Hormone Therapy: Except as provided in the Prescription Medications Section, growth hormone therapy is not covered.

Hearing Aids and Other Devices: Except for cochlear implants or as provided in the Hearing Aids and Evaluations benefit, hearing aids (externally worn or surgically implanted) or other hearing devices are not covered.

Hypnotherapy and Hypnosis Services: Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to: treatment of painful physical conditions, Mental Health Conditions, Substance Use Disorders, or for anesthesia purposes.

Illegal Services, Substances and Supplies: Services, substances and supplies that are illegal as defined by state or federal law.

Individualized Education Program (IEP): Services or supplies, including, but not limited to, supplementary aids and supports as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility: Except to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to: surgery, fertility medications, and other medications associated with fertility treatment.

Investigational Services: Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to: services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and any services or supplies provided by an Investigational protocol.

Motor Vehicle Coverage and Other Available Insurance: When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to a Member (whether or not the Member makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, Our Coordination of Benefits provision shall apply);
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Member is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care: Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Obesity or Weight Reduction/Control: Except as provided in the Nutritional Counseling benefit or as required by law, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to: medical treatment; medications; surgical treatment (including treatment of complications, revisions and reversals); or programs.

Orthognathic Surgery: Except for treatment of the following, orthognathic surgery is not covered:

- orthognathic surgery due to an Injury;
- temporomandibular joint disorder;
- sleep apnea;
- developmental anomalies; or
- Congenital Anomaly.

"Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

Over-the-Counter Contraceptives: Except as provided in the Prescription Medications Section or as required by law, over-the-counter contraceptive supplies are not covered.

Personal Items: Items that are primarily for comfort, convenience, cosmetics, contentment, hygiene, environmental control, education or general physical fitness are not covered, including, but not limited to: telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes, weightlifting equipment, and therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment: Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to: hot tubs; or membership fees to spas, health clubs or other such facilities.

Private-Duty Nursing: Private-duty nursing, including ongoing shift care in the home.

Reversals of Sterilizations: Services and supplies related to reversals of sterilization.

General Exclusions

Riot, Rebellion and Illegal Acts: Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Member's **voluntary participation** in any of the following: a riot, an armed invasion or aggression, an insurrection, a rebellion; or an act deemed illegal by an officer or a court of law.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs: Except as provided in the Medical Benefits Section or for services provided without a separate charge in connection with Covered Services that train or educate a Member, self-help, non-medical self-care, and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs that:
  - teach a person how to use Durable Medical Equipment;
  - teach a person how to care for a family member; or
  - provide a supportive environment focusing on the Member's long-term social needs when rendered by individuals who are not Providers.

Services and Supplies Provided by a Member of Your Family: Services and supplies provided to You by a member of Your immediate family are not covered. "Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary: Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes: Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered. Administrative or qualification purposes include, but are not limited to:

- admission to or remaining in:
  - school, a camp, a sports team, the military; or any other institution.
- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:
  - employment, marriage, insurance, occupational injury benefits, licensure, or certification.
- immigration or emigration

Sexual Dysfunction: Except as provided in the Mental Health Services benefit, treatment, services and supplies (including medications) are not covered for or in connection with sexual dysfunction regardless of cause.

Third-Party Liability: Services and supplies for treatment of Illness, Injury or health condition for which a third-party is or may be responsible.

Travel and Transportation Expenses: Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits Section, travel and transportation expenses are not covered.

Varicose Vein Treatment: Except for the following, treatment of varicose veins is not covered: when there is associated venous ulceration, or persistent or recurrent bleeding from ruptured veins.

Vision Care: Vision care services are not covered, including, but not limited to: routine eye examinations; vision hardware; visual therapy; training and eye exercises; vision orthoptics; surgical procedures to correct refractive errors/astigmatism; and reversals or revisions of surgical procedures which alter the refractive character of the eye.

Wigs: Wigs or other hair replacements regardless of the reason for hair loss or absence.

Work-Related Conditions: Except when a Member is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered. This includes any claims resolved as a result of a disputed claim settlement. If an Illness or Injury could be considered work-related, a Member will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

Prescription Medications Exclusions

Biological Sera, Blood or Blood Plasma

Bulk Powders: Except as included on Our Drug List and presented with a Prescription Order, bulk powders are not covered.

Cosmetic Purposes: Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; anti-aging; repair of sun-damaged skin; or reduction of redness associated with rosacea.

Devices or Appliances: Except as provided in the Medical Benefits Section, devices or appliances of any type, even if they require a Prescription Order are not covered.

Diagnostic Agents: Except as provided in the Medical Benefits Section, diagnostic agents used to aid in diagnosis rather than treatment are not covered.

Foreign Prescription Medications: Except for the following, foreign Prescription Medications are not covered: Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States, or Prescription Medications You purchase while residing outside the United States.

These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered in this section if obtained in the United States.

General Anesthetics: Except as provided in the Medical Benefits Section, general anesthetics are not covered.

Medical Foods: Except as provided in the Medical Benefits Section, medical foods are not covered.

Prescription Medications Exclusions

Medications that are Not Considered Self-Administrable: Except as provided in the Medical Benefits Section or as specifically indicated in this Prescription Medications Section, medications that are not considered self-administrable are not covered.

Nonprescription Medications: Except for the following, nonprescription medications that by law do not require a Prescription Order are not covered: medications included on Our Drug List, medications approved by the FDA, or a Prescription Order by a Physician or Practitioner. Nonprescription medications include, but are not limited to: over-the-counter medications, vitamins, minerals, food supplements, homeopathic medicines, nutritional supplements, and any medications listed as over-the-counter in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

Prescription Medications Dispensed in a Facility: Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed by this benefit if obtained from a Pharmacy.

Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)

Prescription Medications Not Approved by the FDA

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not within a Provider's License: Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications with Lower Cost Alternatives: Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives.

Prescription Medications without Examination: Except as provided in the Virtual Care benefit, whether the Prescription Order is provided by mail, telephone, internet or some other means, Prescription Medications without a recent and relevant in-person examination by a Provider, are not covered. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe: an opioid antagonist to a Member who is at risk of experiencing an opiate-related overdose, or an epinephrine auto-injector to a Member who is at risk of experiencing anaphylaxis. An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

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)

Regence Choice Vision

Regence BlueShield of Idaho, Inc.

Effective September 1, 2021 through August 31, 2022

Regence

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

Vision Benefits		VSP Network	Out-of-Network
Routine Vision Examinations	1 routine examination per member per calendar year	No charge up to the VSP doctor limit	No charge up to the $45 Out-of-Network provider limit
Contact Lens Evaluations and Fitting Examinations	1 contact lens evaluation and fitting examination per member per calendar year	$60 copay	No charge up to the Out-of-Network provider limit
Vision Hardware	1 pair of standard lenses per member per calendar year Contact lenses may be selected once per calendar year in lieu of all other lenses and frame benefits (when you receive contact lenses, you will not be eligible for any frames and/or lenses until the next calendar year)	No charge up to the $150 VSP provider limit or $80 VSP approved wholesale/ retail vendor limit	No charge up to the $70 Out-of-Network provider frame limit or the following Out-of-Network provider limits: Standard lenses: $30 single vision lens, $50 lined bifocal or standard progressive lens, $65 lined trifocal lens, $100 lenticular lens Contact lenses: $105 elective contacts or $210 necessary contact lenses
Low Vision Benefit (Supplemental Testing)	$1,000 limit (combined with supplemental aids) every 2 calendar years	No charge	No charge up to the $125 Out-of-Network provider limit
Low Vision Benefit (Supplemental Aids)	$1,000 limit (combined with supplemental testing) every 2 calendar years	25%	

Additional Discounts

You are entitled to receive a 20% discount toward the purchase of non-covered materials from any VSP Doctor when a complete pair of glasses is dispensed. You are also entitled to receive a 15% discount off of contact lens examination services from any VSP Doctor beyond the covered examination. Professional judgment will be applied when evaluating prescriptions written by an Out-of-Network provider. VSP Doctors may request an additional examination at a discount.
Discount of 15%-20% or 5% off a promotion offer for laser surgery.

Discounts are applied to the VSP Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye examination. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS VISION PLAN, BUT ARE NOT INSURANCE.** Please refer to your benefits booklet or Summary Plan Description for complete details.

Limitations

- discounts do not apply to vision care benefits obtained from Out-of-Network providers;
- 20% discount applies only when a complete pair of glasses is dispensed; and
- discounts do not apply to sundry items, for example, contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frame.

Exclusions

Certain Contact Lens Expenses

- artistically-painted or non-prescription contact lenses;
- contact lens modification, polishing or cleaning;
- refitting of contact lenses after the initial (90-day) fitting period;
- additional office visits associated with contact lens pathology; and
- contact lens insurance policies or service agreements.

Conditions Caused by Active Participation in a War or Insurrection: The treatment of any condition caused by or arising out of a Member's active participation in a war or insurrection.

Conditions Incurred in or Aggravated During Performances in the Uniformed Services: The treatment of any Member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Corneal Refractive Therapy (CRT): Reversals or revisions of surgical procedures which alter the refractive character of the eye, including orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

Corrective Vision Treatment of an Experimental Nature

Cosmetic Services and Supplies: Except for Medically Necessary services and supplies to treat a Congenital Anomaly, cosmetic services and supplies are not covered, including, but not limited to: beautification, cosmetic purposes, aesthetic purposes, or optional cosmetic processes. "Cosmetic" means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

Exclusions

Expenses Before Coverage Begins or After Coverage Ends: Services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

Facility Charges: Services and supplies provided in connection with facility services.

Fees, Taxes, Interest: Except as required by law, the following fees, taxes and interest are not covered: charges for shipping and handling, postage, interest or finance charges that a Provider might bill; excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity.

Government Programs: Except as required by state law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with Us, benefits that are covered (or would be covered in the absence of this plan) by any federal, state or government program are not covered. Additionally, except as required by law for emergency services, government facilities or government facilities outside the service area are not covered.

Investigational Services: Investigational services are not covered, including, but not limited to: services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and any services or supplies provided by an Investigational protocol.

Lens Enhancements: Lens enhancements are not covered, including, but not limited to: anti-reflective coating, color coating, mirror coating, scratch coating, blended lenses, cosmetic lenses, laminated lenses, oversize lenses, premium and custom progressive multifocal lenses, photochromic lenses, tinted lenses, except Pink #1 and Pink #2, or UV (ultraviolet) protected lenses.

Medical or Surgical Treatment of the Eyes: Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Motor Vehicle Coverage and Other Available Insurance: When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to a Member (whether or not the Member makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, Our Coordination of Benefits provision shall apply);
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Member is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care: Non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Orthoptics or Vision Training: Except as provided in the Low Vision benefits, orthoptics, vision training and any associated supplemental testing are not covered.

Personal Items: Items that are primarily for comfort, convenience, cosmetics, contentment, hygiene, aesthetics or other nontherapeutic purposes.

Plano Lenses (Less Than a ± .50 Diopter Power)

Replacements: Replacement of any lost, stolen or broken lenses and/or frames.

Riot, Rebellion and Illegal Acts: Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Member's **voluntary participation** in any of the following: a riot, an armed invasion or aggression, an insurrection, a rebellion, or an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs: Except for services provided without a separate charge in connection with Covered Services that train or educate a Member, self-help, non-vision self-care and training programs are not covered.

Services and Supplies Provided by a Member of Your Family: Services and supplies provided to You by a member of Your immediate family, are not covered. "Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary: Services and supplies that are not Medically Necessary for the treatment of the diagnosis or correction of visual acuity.

Third-Party Liability: Services and supplies for treatment of Illness, Injury or health condition for which a third-party is or may be responsible.

Travel and Transportation Expenses

Two Pair of Glasses in Lieu of Bifocals

Work-Related Conditions: Except when a Member is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered. This includes any claims resolved as a result of a disputed claim settlement. If an Illness or Injury could be considered work-related, a Member will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

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.

Provider and Benefit Inquiries: 1 (844) 299-3041 | Membership Inquiries: 1 (888) 367-2117 - TTY: 711 | PO Box 997100, Sacramento, CA 95899-7100 | vsp.com

NONDISCRIMINATION NOTICE

VSP provides administration for your Regence vision plan. 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:

VSP
Medicare 1-844-872-6065
Commercial 1-844-299-3041
(TTY: 1-800-428-4833)

If you believe that VSP or 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:

Regence

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

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.

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: TTY: 1-800-428-4833).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (ATS : 1-800-428-4833)

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。Medicare: 1-844-872-6065; Commercial: 1-844-299-3041（TTY: 1-800-428-4833）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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833.)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)¶

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (መስማት ለተሳናቸው:- 1-800-428-4833)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: 1-800-428-4833)

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (टिटिवाइ: 1-800-428-4833

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

MAANDO: To a waawi [Adamawa], e woodi balloojima to ekkitaaki wolde caahu. Noddu Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

Language assistance

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-428-4833)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (رقم هاتف الصم والبكم TTY: 1-800-428-4833)