# City of Medford MPOA
# Regence Classic℠

***Effective January 1, 2022 through December 31, 2022***

Regence

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 Deductible | The total deductible you pay per calendar year | $3,000 Individual<br>$6,000 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<br>$10,000 Family | Shared with In-Network |

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) | | $15 copay per visit, deductible waived | 40% |
| Specialist Visits | | $15 copay per visit, deductible waived | 40% |
| 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 | | 20% | 40% |
| Preventive Care/Immunizations | | No charge | 40% |
| Radiology and Laboratory - Outpatient | | 20% deductible waived | 40% |
| Complex Imaging - Outpatient | | 20%, deductible waived | 40% |
| Acupuncture | 30 visits per calendar year | $15 copay per visit, deductiblewaived | 40% |
| Ambulance Services | | 10% | |
| Ambulatory Surgical Center | | 10% | 40% |
| Emergency Room (Including Professional Charges) | | $250 copay per visit, deductible waived | |
| Hearing Aids & Evaluations | | 20% | 40% |
| Home Health Care | 130 visits per calendar year | 20% | 40% |
| Hospice Care | 14 days of respite care per lifetime | 20% | 40% |
| Hospital Care | | 20% | 40% |
| Mental Health/Substance Use Disorder - Inpatient | | 20% | 40% |
| Mental Health/Substance Use Disorder - Outpatient | | 20%, deductible waived | 40% |
| Newborn Home Visits | Within 6 months of age, at least one visit during first 3 months, with up to 3 more available | 0%, deductible waived | Not covered |
| Neurodevelopmental Therapy - Outpatient | 30 visits per calendar year<br>Children under the age of 18 | 20%, deductible waived | 40% |
| Nutritional Counseling | 3 visits per calendar year | 20% | 40% |
| Palliative Care | 30 visits per calendar year | 20% | 40% |
| Rehabilitation Services - Inpatient | 30 days per calendar year | 20% | 40% |
| Rehabilitation Services - Outpatient | 30 visits per calendar year | 20%, deductible waived | 40% |

| Medical Benefits (unless stated otherwise, a deductible applies) | What You Pay |
|---|---|

| | | In-Network | Out-of-Network |
|---|---|---|---|
| Retail Office Visits | Visits to a walk-in clinic located within a retail operation | $15 copay per visit, deductible waived | 40% |
| Skilled Nursing Facility (SNF) Care | 60 days per calendar year | 20% | 40% |
| Spinal Manipulations | 30 visits per calendar year | $15 copay per visit, deductible waived | 40% |
| Virtual Care - Telehealth | Doctor visits via phone or video chat when not in a healthcare facility | **Vendor: MDLive**<br>$10 copay per visit, deductible waived<br><br>**In-Network non-Vendor Provider:**<br>$15 copay per visit, deductible waived | 40% |
| Virtual Care - Telemedicine | Doctor visits via phone or video chat when in a healthcare facility | 20% | 40% |

| Prescription Medication Benefits (unless stated otherwise, a deductible applies) | | 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 |
| Generic | 90-day supply for retail or mail order | $15 retail prescription* / $30 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication |
| Preferred Brand^ | 90-day supply for retail or mail order | $30 retail prescription* / $60 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication |
| Brand | 90-day supply for retail or mail order | $45 retail prescription* /$90 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication |
| Specialty | 30-day supply for retail | $30 participating pharmacy retail prescription |

**1 copay per 30 day supply*
*^$100 cap on member cost share per 30 day retail supply insulin, deductible waived*
*^$300 cap on member cost share for up to 90 day supply of mail order insulin, deductible waived*

| 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. |

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.

# 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。1-888-6347（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 jiik'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៖ បើសិន�អ្នកនិ�យ ��ែខ្ម, សេ�ជំនួយែផ្ក ��
ែ�យមិនគិតឈ្ន
គឺ ��ង ��នសំ�ប់បំែរអ្នក។ ចូរ
ទូរស័ព្ទ 1888 6347 (TTY: 711)។

ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ਼ ਪੰ ਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ਼ ਭਾਸ਼ਾ ਿਵੱਚਸਹਾਇਤਾ 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: तपाइले नेपाली बोल्नु ्छ भने तपाइको िन ्ः भाषा सहायता सेवाहरू िनःशुल्क उपलब्ध छ । फोन गनहोस् 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: ถาคุณพูดภาษาไทย
คุณสามารถใชบรการชวย เหลอื ทางภาษาไดฟร ี
โทร 1-888- 344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້ າຫ ່ ານເວ ົ້ າພາສາ ລາວ,
ການບ ໍ ລ ິ ການຊ ່ ວຍເ ສ ີ ມ ຄ ່ າພາສາ, ໂດຍ ບ ໍ ່ ເ ສ ັ ຽ ງ ຄ ່ າ, ແມ ່ ນ ມ ີ ພ ້ ອມໃ ຫ ້ ທ ່ ານ.
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)

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