Regence

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

SUMMARY OF CHANGES: City of Vancouver (Self-Funded 51+)

This document summarizes the changes and potential changes to Regence's standard documents describing benefits effective with the first renewal on or after January 1, 2025 (unless specifically noted otherwise). If there is a decline option below, the Group must select "Decline" in the box for that change or Regence will include the change in the proposed documents it sends to the Group for approval. Certain changes do not present an option to decline because it is not operationally feasible for Regence to administer differently. If Group does "decline" any change, Regence may include the standard language in the applicable draft documents that Regence provides to the Group for approval and adoption. It is the Group's responsibility to review and confirm all choices. If there is any inconsistency between this Summary of Changes and the plan documents the terms of the plan documents will prevail.

- **Changes below are subject to change pending applicable regulatory rulemaking.**

NOTE: Any estimated pricing impacts indicated below are based on Regence's overall book of business experience and do not represent an actual estimate of the Group's potential pricing impact. Actual pricing impacts will vary based on a variety of factors specific to the Group, including utilization and membership demographics. The estimated pricing impacts are provided as a courtesy and should not be considered advice.

FEDERAL MANDATED CHANGES – applies to all plans unless otherwise specified

Benefits	1/2024	1/2025	Mandate
2025 Internal Revenue Service (IRS) High Deductible Health Plan (HDHP) Deductible and Out-of-Pocket Maximum (OOPM) *Only Applies to HSA 3.0 Plan* Estimated Pricing Impacts: *Will vary by Group*	**2024 HSA Deductible and OOPM as mandated by the IRS**: Minimum Deductible: $1,600 Individual / $3,200 Family Maximum Out-of-Pocket Maximum: $8,050 Individual / $16,100 Family	**2025 HSA Deductible and OOPM as mandated by the IRS**: The IRS released the final guidance on updated Deductible and OOPM amounts on HSA plans. Cost share amounts updated to the following: Minimum Deductible: $1,650 Individual / $3,300 Family Maximum Out-of-Pocket Maximum: $8,300 Individual / $16,600 Family	Section 223 of the Internal Revenue Code Applies to CoV - No decision required.
Balance Billing: Ground Ambulance Estimated Pricing Impacts: *$1.00 PMPM* *($2.00 PEPM)* *Pricing impact due to additional Provider Reimbursement change* **Decline** ☐	Balance billing applied when services were billed by an Out-of-Network (OON) ground ambulance provider. Balance billing occurs when the member is billed for balances beyond any Deductible, Copayment or Coinsurance for covered services by an OON provider when their billed amount is not fully reimbursed by us.	Balance billing no longer applies. These providers will be responsible to write-off the difference between their charge and our payment to them on covered services rendered.	WASHINGTON SSB 5986 Applies to CoV - Requires a decision by GB.

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STATE MANDATED CHANGES – applies to all plans unless otherwise specified

Benefits	1/2024	1/2025	Mandate
Pharmacy: HIV Prophylaxis Estimated Pricing Impacts: *Minimal* **Decline** ☐	Medications for HIV Post-Exposure Prophylaxis (PEP) were covered at regular plan cost shares when on our Drug List.	As mandated, coverage is required for HIV Post-Exposure Prophylaxis (PEP) drugs or therapies following patient's possible exposure to HIV. Coverage includes a full 28-day course of therapy and repeat exposures, without preauthorization. **Non-HSA Eligible plans**: In-Network medicationson our Drug List and services are not subject to Deductible, or any other cost shares. **HSA Eligible plans**: In-Network medications on our Drug List and services are subject to the IRS Minimum Deductible ($1,650 for an Individual and $3,300 for a Family), and then covered at 0% member cost share. Out-of-Network medications on our Drug List and services are covered at regular cost shares. Note: This differs from HIV pre-Exposure Prophylaxis drugs (PrEP), which are currently covered under Affordable Care Act (ACA) according to United States Preventive Services Task Force (USPSTF) guidelines.	WASHINGTON SSB 6127 Applies to CoV - Requires a decision by GB.

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STATE MANDATED CHANGES – applies to all plans unless otherwise specified

Benefits	1/2024	1/2025	Mandate
Pharmacy: Reducing Cost of Inhalers and Epinephrine Autoinjectors Estimated Pricing Impacts: *$0.20 PMPM* *($0.40 PEPM)* **Decline** ☐	Medications for corticosteroids and epinephrine autoinjectors were covered at regular plan cost shares when on our Drug List.	As mandated, the member cost shares for certain corticosteroid inhalers for asthma and certain epinephrine autoinjector products containing at least two autoinjectors on the Drug List are capped according to below. **Corticosteroid Inhalers for Asthma:** **Non-HSA Eligible** and **HSA Eligible plans:** **Retail and Home Delivery:** $35 copay cap per 30-day supply, Deductible waived. $105 copay cap up to 90-day supply, Deductible waived. Any cost sharing paid by enrollee must be applied toward Deductible. **Epinephrine Autoinjectors Two Pack:** **Non-HSA Eligible:** **Retail and Home Delivery:** $35 copay cap (per two pack) per 30-day supply, Deductible waived. $105 copay cap (per two pack) up to 90-day supply, Deductible waived. Any cost sharing paid by enrollee must be applied toward plan Deductible. **HSA Eligible Plans:** **Retail and Home Delivery:** Subject to IRS Minimum Deductible ($1,650 for an Individual and $3,300 for a Family), then $35 copay cap (per two pack) per 30-day supply. Subject to IRS Minimum Deductible ($1,650 for an Individual and $3,300 for a Family), then $105 copay cap (per two pack) up to 90-day supply. Any cost sharing paid by enrollee must be applied toward plan Deductible.	WASHINGTON SHB 1979 Applies to CoV - Requires a decision by GB.

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BENEFIT, LANGUAGE AND ADMINISTRATIVE CHANGES – applies to all plans unless otherwise specified

Benefits	1/2024	1/2025
Balance Billing for Services Outside of the United States *Language Change only*	Balance billing from providers outside of the United States was not specifically addressed in the benefit booklet.	Benefit booklet updated to the following: Covered services received from providers outside the United States may not be subject to state or federal protections from surprise or balance billing, and therefore the member may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. No benefit changes have been made.
BlueCard Language *Language Change only*	Healthcare services received outside of the geographic area are paid when seen by a Host Blue provider.	BlueCard language has been simplified and made clearer. No benefit changes have been made.

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BENEFIT, LANGUAGE AND ADMINISTRATIVE CHANGES – applies to all plans unless otherwise specified

Benefits	1/2024	1/2025
Detoxification *Language Change only* **Decline** ☐	This separate benefit category was stated in the member benefit booklet, but administration was applied under the Mental Health and Substance Use Disorder (MHSUD) or Emergency Room benefit categories.	Removed this separate benefit category as benefits continue to be covered under the MHSUD or Emergency Room benefit categories. No benefit changes have been made. Applies to CoV - Requires a decision by GB. DBP reccomends accepting this language change.
Dialysis *Language Change only*	Dialysis services stated as covered in both inpatient and outpatient settings.	Removed specific reference to inpatient setting, as a member is not admitted for a Dialysis service alone. Services are covered while inpatient when admitted for another condition. No benefit changes have been made.
Durable Medical Equipment (DME) / Preventive Care for Chronic Conditions: Continuous Glucose Monitors (CGM) Estimated Pricing Impacts: *Minimal* **Decline** ☐	Non-Therapeutic CGMs and supplies were not covered.	Non-Therapeutic CGMs and supplies are covered. **Non-HSA Eligible plans:** CGMs covered under DME. Regular plan cost shares apply. Also covered under Pharmacy benefits at the applicable tier level, if on the Drug List. **HSA Eligible plans**: CGMs covered under Preventive Care for Chronic Conditions. Deductible waived, Coinsurance applies. Also covered under Pharmacy benefits at the applicable tier level, if on the Drug List. Applies to CoV - Requires a decision from GB. Both plans: CGM supplies to be covered under DME and Pharmacy benefits at the applicable cost shares listed above.
Exclusions: Cosmetic / Reconstructive Services and Supplies - Gender-Affirming Treatment *Language Change only*	This exclusion does not apply to services that are prescribed as medically necessary for Gender-Affirming Treatment and are in accordance with accepted standards of care.	Given the changing state laws within the national landscape, clarified the language to be consistent with other general exclusions to state that our health plans only cover treatments that are legally rendered in accordance with applicable law. Thus, the exclusion has been altered to: This exclusion does not apply to services that are prescribed as Medically Necessary for Gender-Affirming Treatment to the extent such services are permitted under applicable law and are in accordance with accepted standards of care.

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BENEFIT, LANGUAGE AND ADMINISTRATIVE CHANGES – applies to all plans unless otherwise specified

Benefits	1/2024	1/2025
Exclusions: Liposuction for the Treatment of Lipedema Estimated Pricing Impacts: *$0.50-1.00 PMPM* *($1.00-2.00 PEPM)* *May vary significantly based on prevalence of condition* **Decline** ☐	Liposuction for the Treatment of Lipedema was not covered.	Treatment is now covered when medical policy criteria is met. Applies to CoV - Requires a decisoin by GB.
Exclusions: Subscription, Membership and Access-Related Fees *Language Change only*	Exclusion was not specifically stated.	Fees for accessing care, treatment, or advice are not covered, whether the access is for virtual or in-person care. Excluded fees include, but are not limited to: • concierge fees; • subscription fees; • membership fees; • retainer fees; • VIP or priority access fees; and • any other access-related fees. No benefit changes have been made.
Livongo **N/A for COV**	Livongo offered a suite of products: Diabetes Management, Hypertension Management, Weight Management and Diabetes Prevention. The programs focus on improving lifestyle habits to improve health. These services were marketed as offered by Livongo.	These products will no longer be offered under the Livongo brand name. Moving forward, these products will be serviced through Teladoc Health. Changed the name from Diabetes Prevention to Pre-Diabetes Management.

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Benefits	1/2024	1/2025
Pharmacy: Opioid Rescue Medication Value List	List was referred to as Naloxone Value List.	The reference to Naloxone Value List changed to Opioid Rescue Medication Value List as new opioid antagonists are coming into the market where naloxone is not the primary ingredient.
Radiology: Diagnostic and Supplemental Breast Examinations Estimated Pricing Impacts: *Minimal* **Decline** ☐	**Non-HSA Eligible plans**: Out-of-Network (OON) services covered at 0%-member cost shares. **HSA Eligible plans**: Deductible applied and then covered at 0%-member Coinsurance.	Revised OON cost shares. **Both plans**: OON services subject to the Deductible and Coinsurance. Applies to CoV - Requires a decision by GB.

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)