City of Vancouver

Regence Preferred- Retiree Spouse and Dependents

Preferred

Effective January 01, 2025 through December 31, 2025

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

Cost Share Details		Preferred Network	Participating Network	Nonparticipating Network
Annual Medical Deductible	The total deductible You pay per calendar year		$50 Individual $100 Family	
Annual Prescription Deductible	The total deductible You pay per calendar year for prescription medications		Not applicable	
Annual Out-of-Pocket Maximum	The combined total for Your deductible(s), coinsurance and copays per calendar year		$2,500	

Be aware that Your actual costs for Covered Services provided by a Nonparticipating Network provider may exceed the Out-of-Pocket Maximum amount. In addition, Nonparticipating providers and Nonparticipating pharmacies 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		
		Preferred Network	Participating Network	Nonparticipating Network
Primary Care Visits (for Illness or Injury)		Covered in full after deductible	20%	20%
Specialist Visits		Covered in full after deductible	20%	20%
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		Covered in full after deductible	20%	20%
Preventive Care / Immunizations	Wellness Rewards available	Covered in full	Covered in full	20%
Radiology and Laboratory - Outpatient		Covered in full after deductible	20%	20%
Complex Imaging - Outpatient	CT / PET / SPECT scans, MRIs, MRAs, etc.	Covered in full after deductible	20%	20%
Acupuncture	Unlimited visits per calendar year	Covered in full after deductible	20%	20%
Ambulance Services	Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment	Covered in full after deductible		
Ambulatory Surgical Center		Covered in full after deductible	20%	20%
Emergency Room	Facility and professional services	$25 copay per visit		
Hearing Instruments and Services	Up to $3,000 per ear with hearing loss every 36 months for hearing instruments, including bone conduction hearing devices Excludes: over-the-counter hearing aids, routine hearing examinations, batteries and cords, and assistive listening devices	Covered in full	Covered in full	20%, deductible waived
Hospital Care	See Ambulatory Surgical Center for cost reduction option	Covered in full after deductible	20%	20%
Maternity Care		Covered in full after deductible	20%	20%
Mental Health / Substance Use Disorder - Inpatient		Covered in full after deductible	Covered in full after deductible	20%
Mental Health / Substance Use Disorder - Outpatient		Covered in full after deductible	Covered in full after deductible	20%
Neurodevelopmental Therapy	Unlimited visits per calendar year	Covered in full after deductible	20%	20%

Medical Benefits *unless stated otherwise, a deductible applies*		What You Pay		
		Preferred Network	Participating Network	Nonparticipating Network
Rehabilitation Services - Inpatient	Unlimited visits per calendar year	Covered in full after deductible	20%	20%
Rehabilitation Services - Outpatient	Unlimited visits per calendar year	Covered in full after deductible	20%	20%
Skilled Nursing Facility	Unlimited visits per calendar year	Covered in full after deductible	20%	20%
Spinal Manipulations	Unlimited visits per calendar year	Covered in full after deductible	20%	20%
Virtual Care - Telehealth	Doctor visits via phone or video chat when not in a healthcare facility (includes Mental Health visits)	Covered in full after deductible	Covered in full after deductible	20%
	Doctor on Demand – national network of board-certified physicians, licensed therapists, & psychiatrists. 24/7/365 for minor medical care	Covered in full after deductible	N/A	N/A

Prescription Medication Benefits		What You Pay
Tier 1	365-day supply / retail prescription or home delivery	20% retail prescription* / 20% home delivery (mail-order) prescription
Tier 2	365-day supply / retail prescription or home delivery	20% retail prescription* / 20% home delivery (mail-order) prescription
Tier 3	365-day supply / retail prescription or home delivery	20% retail prescription* / 20% home delivery (mail-order) prescription
Specialty Drugs	365-day supply / retail prescription	Refer to tiers 1, 2 and 3 above for specialty drugs

- **1 copay per 30-day supply*
- *Cost Shares for insulin, certain inhaled asthma medications and epinephrine autoinjectors (per 2 pack), for both retail and home delivery, will not exceed $35 per 30-day supply; or $105 per 90-day supply*
- *$0 for each self-administrable Cancer Chemotherapy medication*
- *You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and / or coinsurance*
- *Pharmacy out of pocket limit: $500 individual/calendar year*
- *More information about prescription drug coverage, including tier specific information, is available at https://regence.com/go/2025/CC/3tier*

Value-Added Services	
Your Regence coverage includes access to the value-added services detailed here. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS.** For additional information regarding any of these value-added services, visit Our website or contact Customer Service.	
Kidney Health Management	If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD).
Mobile APP	Quick access to: ID card, chat with Customer Service, View Claims, Estimate Treatment Cost, Pharmacy pricing.
Nurse Advice	You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care 24 / 7. However, if You are experiencing a medical emergency, immediately call 911 instead.
Pregnancy Program	Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions; the Pregnancy Program can help.
Regence Advantages	Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services.
Regence Empower	Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. Wellness Rewards available.

Out-of-Area Services

Outside of the service area, Claimants have Preferred Network benefits at Blue Cross and / or Blue Shield (Blue Plan) facilities across the country through the BlueCard® Program and worldwide through the Blue Cross Blue Shield Global® Core Program. Any other services will not be covered when processed through any Inter-Plan arrangements. Outside Preferred Network, You may be balance billed. Call 1 (800) 810 BLUE (2583) to learn how to get access.

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.
Is there a cost for "Covered in full"?	No, if Your benefit is covered in full there is no copay or deductible.
What if I need access to specialty care?	You can receive care from any Preferred Network provider without a referral. For some services, prior authorization may be required.

Frequently Asked Questions

Do I need a referral?

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 Claimants under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and Claimants.

Customer Service: 1 (866) 240-9580 - TTY: 711 | 200 SW Market Street 11th Floor, Portland, OR 97201 | regence.com

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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, sex, sexual orientation or gender identity, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

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, available 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at
https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

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, koji' 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 balloojima 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. ໂທ 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)