2019/2020

Plan Description: REGENC-PPO 3500/70% -OR
Product: PPO
Network: Preferred

Provider: Regence BCBS of Oregon
Member Services Phone #: 1-888-367-2116
Plan Website Address: http://www.regence.com

Benefit	In-Network	Out-of-Network
General Plan Information		
Lifetime Maximum	• Unlimited	• Unlimited
Calendar Year Deductible - Individual	• $3,500	• $3,500
Calendar Year Deductible - Family	• $7,000	• $7,000
Carrier Coinsurance	• 70%	• 50%
Member Coinsurance	• 30%	• 50%
Calendar Year Out-of-Pocket Max - Individual	• $7,000	• $7,000
Calendar Year Out-of-Pocket Max - Family	• $14,000	• $14,000
Office Visits		
Primary Care Physician Visit	• $15 BDTC; $30 copay per visit	• Deductible then 50%
Virtual Visit	• $10 copay	• Not Covered
Specialist Visit	• $15 BDTC; $30 copay per visit	• Deductible then 50%
Specialist Referral Required	• No	• No
Hospital Care		
Hospital Care - Inpatient	• Deductible then 30%	• Deductible then 50%
Hospital Care - Outpatient	• Deductible then 30%	• Deductible then 50%
Emergency Care		
Emergency Room (In-Area)	• $100 copay per visit (waived if admitted) then 30%	• $100 copay per visit (waived if admitted) then 30%
Urgent Care Facility	• $30 copay per visit	• Deductible then 50%
Prescription		
Tier 1 Retail	• $15 copay, $10 copay for self administrable cancer chemotherapy drugs	• $15 copay, $10 copay for self administrable cancer chemotherapy drugs
Tier 2 Retail	• $55 copay, $50 copay for self administrable cancer chemotherapy drugs	• $45 copay, $50 copay for self administrable cancer chemotherapy drugs
Tier 3 Retail	• $120 copay, $100 copay for self administrable cancer chemotherapy drugs	• $100 copay, $100 copay for self administrable cancer chemotherapy drugs
Tier 4 Retail	• 50% up to $500 maximum copay/retail prescription	• 50% up to $500 maximum copay/retail prescription
Mail Order	• 3X Retail	• 3X Retail
Medicare Part D Compatible	• Yes	• Yes
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal Care)	• Deductible then 30%	• Deductible then 50%
Preventive Care		
Preventive Services	• No Charge	• Deductible then 50%
Other Services		
Diagnostic X-Ray, Scans & Lab	• No charge for first $400 per year, Ded then 30%	• No charge for first $400 per year, Ded then 50%
Chiropractic Care	• 30% Limited to 12 visits per calendar year	• 50%. Limited to 12 visits per calendar year

This benefit summary has been prepared by a licensed Insurance carrier or broker based on documents provided by the applicable licensed Insurance carrier. Please refer to the Plan Document and Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document or COC, the Plan Document and COC govern. This health insurance plan is part of a large group health plan, as such Medicare is the secondary payer for any insured member that is enrolled in Medicare and this plan. If eligible for Medicare due to ESRD, Medicare becomes primary payer after thirty months of Medicare eligibility. If member is a COBRA participant, Medicare is the primary payer.