Jackson County Health Plan

Regence Innova®

Effective July 1, 2019 through June 30, 2020

Regence

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 Deductible	The total deductible you pay per calendar year	$750 Individual $2,250 Family	Shared with Preferred Network	Shared with Preferred Network
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	$2,250 Individual $6,750 Family	Shared with Preferred Network	Shared with Preferred Network

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 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		
Primary Care Visits (for Illness or Injury)	Expanded Office Services (medical, surgical and therapeutic injections) are covered when provided by a professional provider and received in the provider's office and billed as such.	$20 copay per visit, deductible waived 10% coinsurance No charge for Expanded Office Services	30% coinsurance	30% coinsurance
Specialist Visits		$20 copay per visit, deductible waived 10% coinsurance No charge for Expanded Office Services	30% coinsurance	30% coinsurance
Urgent Care Visits		$20 copay per visit, deductible waived 10% coinsurance No charge for Expanded Office Services	30% coinsurance	30% coinsurance
Other Professional Services		10%	30%	30%
Preventive Care/Immunizations		0%, deductible waived	0%, deductible waived	30%
Ambulance Services		20%	20%	20%
Ambulatory Surgical Center		5%	30%	30%
Complementary Care	Chiropractic spinal manipulations and acupuncture services from any licensed provider $1,000 limit per calendar year	$20 copay per visit, deductible waived, copayment does not apply to the out-of-pocket limit.	$20 copay per visit, deductible waived, copayment does not apply to the out-of-pocket limit.	$20 copay per visit, deductible waived, copayment does not apply to the out-of-pocket limit.
Emergency Room (Including Professional Charges)		$100 copay per visit, then deductible and 10% coinsurance	$100 copay per visit, then deductible and 10% coinsurance	$100 copay per visit, then deductible and 10% coinsurance
Genetic Testing	No charge for the first $500 (see Radiology and Laboratory - Outpatient), Preferred, Participating and Nonparticipating combined, deductible waived. Once the limit is met, the deductible and coinsurance applies.	No charge for the first $500 per calendar year, then deductible and 10% coinsurance	No charge for the first $500 per calendar year, then deductible and 30% coinsurance	No charge for the first $500 per calendar year, then deductible and 30% coinsurance
Hearing Aids & Evaluations		10%	30%	30%
Hearing Examinations	1 exam per calendar year	10%, deductible waived	30%	30%
Home Health Care	180 visits per calendar year	10%	30%	30%
Hospice Care	14 days of respite care per lifetime	10%	30%	30%
Hospital Care		10%	30%	30%
Durable Medical Equipment	Limited to 1 wig after chemotherapy per lifetime.	10%	30%	30%

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay		
Mental Health/Substance Use Disorder - Inpatient		10%	30%	30%
Mental Health/Substance Use Disorder - Outpatient		$20 copay per outpatient office / psychotherapy visit, deductible waived; all other services 10% coinsurance	30%	30%
Neurodevelopmental Therapy - Outpatient	Unlimited visits per calendar year Children under the age of 18	10%	30%	30%
Nutritional Counseling	3 visits per lifetime (Bariatric Services not applicable)	10%	30%	30%
Palliative Care	30 visits per calendar year	10%	30%	30%
Radiology and Laboratory - Outpatient	No charge for the first $500, Preferred, Participating and Nonparticipating combined, deductible waived. Once the limit is met, the deductible and coinsurance applies.	No charge for the first $500 per calendar year, then deductible and 10% coinsurance	No charge for the first $500 per calendar year, then deductible and 30% coinsurance	No charge for the first $500 per calendar year, then deductible and 30% coinsurance
Rehabilitation Services - Inpatient	30 days per calendar year	10%	30%	30%
Rehabilitation Services - Outpatient	60 visits per calendar year	10%	30%	30%
Skilled Nursing Facility (SNF) Care	100 days per calendar year	10%	30%	30%
Spinal Manipulations - Osteopathic		10%	30%	30%
Telehealth		$20 copay per session, deductible waived	$20 copay per session, deductible waived	Not covered

Vision Benefits		Preferred Network	Participating Network	Nonparticipating Network
Routine Vision Examinations	Limited to 1 routine eye exam / year for children up to age 19 and 1 routine exam every 2 / years for individuals 19 and older.	$20 copay / exam	$20 copay / exam	$20 copay / exam
Vision hardware	Limited to $265 maximum for covered vision hardware every 2 / years and you pay any balance for individuals 19 and older. No limit for covered vision hardware for children up to age 19.	No charge up to $265 hardware maximum	No charge up to $265 hardware maximum	No charge up to $265 hardware maximum

Prescription Medication Benefits		What You Pay
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	$10 retail prescription / $25 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication
Preferred Brand	90-day supply for retail or mail order	$20 retail prescription / $50 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication
Brand	90-day supply for retail or mail order	$40 retail prescription / $100 mail order prescription / $100 for each self-administrable Cancer Chemotherapy medication
Specialty	30-day supply for retail	Refer to Generic, Preferred Brand and Brand above for participating pharmacy retail prescription

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。1-888-344-6347（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៖ 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)