Regence Classic℠

Preferred

Effective December 1, 2022 through November 30, 2023

Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

Cost Share Details		In-Network	Out-of-Network
Annual Medical Deductible	The total deductible you pay per calendar year	$3,000 Individual $9,000 Family	Shared with In-Network
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	$5,500 Individual $11,000 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)		$30 copay per visit, deductible waived	40%
Specialist Visits		$30 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		Covered in full	40%
Radiology and Laboratory - Outpatient		20%	40%
Complex Imaging - Outpatient	CT/PET/SPECT scans, MRIs, MRAs, etc.	20%	40%
Acupuncture	12 visits per calendar year	$30 copay per visit, deductible waived	40%
Ambulance Services	Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment	20%	
Ambulatory Surgical Center		10%	40%
Emergency Room	Facility and professional services	$100 copay per visit, then deductible and 20% coinsurance	
Home Health Care	130 visits per calendar year	20%	40%
Hospice Care	14 days per lifetime for Respite Care only	20%	40%
Hospital Care - Inpatient		20%	40%
Hospital Care - Outpatient		20%	40%
Maternity	Routine maternity and complications due to pregnancy	20%	40%
Mental Health/Substance Use Disorder - Inpatient		20%	40%
Mental Health/Substance Use Disorder - Outpatient		$30 copay per outpatient office/psychotherapy visit, deductible waived	40%
Neurodevelopmental Therapy	25 visits per calendar year	$30 copay per visit, deductible waived	40%
Nutritional Counseling	3 visits per calendar year	20%	40%

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
		In-Network	Out-of-Network
Palliative Care	30 visits per calendar year	20%	40%
Rehabilitation Services - Inpatient	30 days per calendar year	20%	40%
Rehabilitation Services - Outpatient	25 visits per calendar year	$30 copay per visit, deductible waived	40%
Retail Office Visits	Visits to a walk-in clinic located within a retail operation	$20 copay per visit, deductible waived	40%
Skilled Nursing Facility	60 days per calendar year	20%	40%
Spinal Manipulations	12 spinal manipulations per calendar year	$30 copay per visit, deductible waived	40%
Virtual Care - Telehealth	Doctor visits via phone or video chat when not in a healthcare facility	**Vendor:** $10 copay per visit, deductible waived **In-Network non-Vendor Provider:** $30 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
Preferred Generic	90-day supply for retail or mail order	$10 retail prescription* / $30 mail order prescription
Generic	90-day supply for retail or mail order	25% retail prescription / 25% mail order prescription
Preferred Brand	90-day supply for retail or mail order	35% retail prescription / 35% mail order prescription
Brand	90-day supply for retail or mail order	50% retail prescription / 50% mail order prescription
Preferred Specialty	30-day supply for retail	40% participating pharmacy retail prescription
Specialty	30-day supply for retail	50% participating pharmacy retail prescription

**1 copay per 30 day supply*
***Insulin Cost Share Cap:** Retail and Mail Order: $100 cap on member cost share per 30 day supply, deductible waived; $300 cap on member cost share up to 90 day supply, deductible waived*
0% for each self-administrable Cancer Chemotherapy medication, deductible waived
More information about prescription drug coverage is available at https://regence.com/go/2022/WW/6tierLG

Other Services		What You Pay	
		In-Network	Out-of-Network
Employee Assistance Program (EAP)	4 mental health counseling visits per issue	Covered in full	Not covered

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.