Regence BlueShield of Idaho, Inc. Individual Direct Plan Highlights
Gold 1000, Silver Essential 3500, Silver 3000, EPO Bronze Essential 7150
1/1/2017

Regence

Plan Information

- Provider networks: Members have direct access to their choice of providers. Member cost-sharing is lowest for In-Network providers. If a member chooses an Out-of-Network provider, the member may be required to pay costs above the allowed amount. The maximum allowed amount for services from a nonparticipating facility is $1,500 per day.
- Ambulatory Surgical Center: While many surgical procedures are best performed in a hospital setting, many can be safely and effectively performed in an Ambulatory Surgery Center (ASC) at a lower cost. If your doctor recommends that you have one of these surgeries, you may pay less out-of-pocket if you choose to have it performed at an ASC. For more information, or a list of services that can be performed at an ASC, contact Regence customer service.
- Telehealth visits (conducted via phone, secure online video, mobile app or web) are available.
- Separate deductible and separate out-of-pocket maximum amounts per calendar year for In-Network and Out-of-Network providers. The calendar year deductible and out-of-pocket maximum applies to all covered expenses except where noted. When the out-of-pocket maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year.
- Member responsibility for In-Network services is indicated below, after In-Network deductible is met and until out-of-pocket maximum is met, except where noted. Member responsibility for Out-of-Network services is 50% Gold 1000, Silver Essential 3500, Silver 3000 and 90% EPO Bronze Essential 7150 after Out-of-Network deductible is met and until out-of-pocket maximum is met, except where noted.

Calendar Year Deductible

In-Network	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Individual/Family	$1,000/$2,000	$3,500/$7,000	$3,000/$6,000	$7,150/$14,300

Out-of-Network	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Individual/Family	$5,000/$10,000	$10,000/$20,000	$10,000/$20,000	$14,300/$28,600

Calendar Year Out-of-Pocket Maximum

In-Network	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Individual/Family	$6,500/$13,000	$7,150/$14,300	$7,000/$14,000	$7,150/$14,300

Out-of-Network	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Individual/Family	$200,000/None	$200,000/None	$200,000/None	$200,000/None

10 Essential Health Benefits - Covered Services

Be aware that the members' actual costs for covered services provided by an out-of-network provider may exceed this policy's out-of-network out-of-pocket maximum amount. In addition, out-of-network providers and nonparticipating pharmacies can bill the member for the difference between the amount charged and our allowed amount and that amount does not count toward any out-of-pocket maximum.

1. Ambulatory Patient Services

(Outpatient Care)	In-Network Member Responsibility			
	Gold 1000	**Silver Essential 3500**	**Silver 3000**	**EPO Bronze Essential 7150**
Office Visits	Primary care: Not subject to deductible $20 copay Specialist Care: $40 copay Urgent Care: $40 copay	Primary, Specialist and Urgent Care: 3 upfront visits at $30 copay, then 10% after deductible	Primary care: Not subject to deductible $30 copay Specialist Care: $50 copay Urgent Care: $50 copay	Primary, Specialist and Urgent Care: 2 upfront visits at $60 copay, then 0% after deductible
Ambulatory Surgical Center services and supplies	10%	10%	20%	0%
Hospital outpatient services and supplies	20%	10%	30%	0%
Complex Outpatient Imaging (CTs, MRIs, PETs)	20%	10%	30%	0%

2. Emergency Services

In-Network benefits apply regardless of provider network	**Gold 1000**	**Silver Essential 3500**	**Silver 3000**	**EPO Bronze Essential 7150**
Emergency Room	20%	10%	30%	0%
Ambulance	20%	10%	30%	0%

3. Hospitalization	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Inpatient services and supplies	20%	10%	30%	0%

4. Maternity and Newborn Care	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Pregnancy care, childbirth and complications of pregnancy, and Newborn Care	20%	10%	30%	0%

5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Inpatient Services	20%	10%	30%	0%
Outpatient Services	20%	10%	30%	0%

6. Prescription Medications[1]	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Calendar Year Deductible In-Network medical deductible applies unless otherwise specified	Medical deductible waived for Tier 1 and Tier 2	Medical deductible waived for Tier 1	Medical deductible waived for Tier 1 and Tier 2	Medical deductible waived for Tier 1
Tier 1: Preferred Generic	$8 Retail / $16 Mail	$10 Retail / $20 Mail	$10 Retail / $20 Mail	$20 Retail / $40 Mail
Tier 2: Non-Preferred Generic	25% Retail / 20% Mail	25% Retail / 20% Mail	25% Retail / 20% Mail	0% Retail / 0% Mail
Tier 3: Preferred Brand	25% Retail / 20% Mail	35% Retail / 30% Mail	35% Retail / 30% Mail	0% Retail / 0% Mail
Tier 4: Non-Preferred Brand	50% Retail / 45% Mail	50% Retail / 45% Mail	50% Retail / 45% Mail	0% Retail / 0% Mail
Tier 5: Preferred Specialty	40%	40%	40%	0%
Tier 6: Non-Preferred Specialty	50%	50%	50%	0%

[1] All out-of-pocket expenses go towards In-Network Medical Out-of-Pocket Maximum. Essential Formulary applies to all plans. Members can receive a $5 or 5% discount for prescription medications at Preferred Pharmacies.

Retail: Up to 90-day supply for Tiers 1, 2, 3 and 4.

Mail-Order: Up to 90-day supply. Specialty Medications:. Up to 30-day supply per fill.

7. Rehabilitative and Habilitative Services and Devices	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Rehabilitation (Inpatient)	20%	10%	30%	0%
Rehabilitation (Outpatient) • 20 visits per calendar year	20%	10%	30%	0%
Habilitative Services (Inpatient)	20%	10%	30%	0%
Habilitative Services (Outpatient) • 20 visits per calendar year	20%	10%	30%	0%
Durable Medical Equipment	20%	10%	30%	0%

8. Laboratory Services	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Outpatient Radiology and Laboratory and Diagnostic imaging including X-rays (Complex Outpatient Imaging refer to Ambulatory Patient Services)	20%	10%	30%	0%

9. Preventive Services	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
In-Network not subject to deductible	0%	0%	0%	0%

10. Pediatric Services	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Pediatric Dental • Various limits apply • Covered for members up to age 19 • Member responsibility indicated is for both in-Network / Out-of-Network services	Preventive: 0% / Basic: 20% / Major: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Preventive: 0% / Basic: 20% / Major: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Preventive: 0% / Basic: 20% / Major: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Preventive: 0% / Basic: 20% / Major: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum
Pediatric Vision • Covered for members up to age 19 • Member responsibility indicated is for both in-Network / Out-of-Network services • One routine eye exam per calendar year • One pair (two lenses) and one standard frame per calendar year • Contacts in lieu of glasses	Eye exam: 0% / Vision Hardware: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Eye exam: 0% / Vision Hardware: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Eye exam: 0% / Vision Hardware: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum	Eye exam: 0% / Vision Hardware: 50% Deductible waived on all services Applies to In-Network out-of-pocket maximum

Other Covered Services	Gold 1000	Silver Essential 3500	Silver 3000	EPO Bronze Essential 7150
Spinal Manipulations • 18 spinal manipulations per calendar year	20%	10%	30%	0%

Additional Information	All Plans
Outside the Service Area	Members have the security of knowing they can access Blue Cross and/or Blue Shield (Blue Plan) providers across the country and worldwide through the BlueCard® Program. Out-of-Network plan benefits apply as described within this document.
Preventive Services	Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings. Also included is provider counseling for tobacco use cessation and generic medications prescribed for tobacco use cessation. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time). Additionally, We cover all United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants and surgical sterilization.

Questions and Answers

How do I find out more about the providers available in my network?	• You can visit www.regence.com/find-a-doctor to search for providers in your network. • The network available is Preferred.
Do I need to select a Primary Care Provider (PCP)?	• No
What if I need to access care after hours, or if my regular provider's office is closed?	• If you are experiencing a medical emergency, you should call 911. If your medical situation is urgent, and you do not feel you can wait to see your regular provider, you can visit www.regence.com/find-a-doctor to search for urgent care or emergency care services.
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.
What if I need information in another language?	• If you need help obtaining this information in other languages, please contact our Customer Service number at 1-888-232-5763 for additional information. (TTY users should call 711). Hours are 6:00 a.m. to 6:00 p.m., Monday through Friday . • *Esta información se encuentra disponible gratis en otros idiomas. Comuníquese con nuestro Servicios para Miembros al 1-888-232-5763 para obtener información adicional. Los usuarios de TTY deben llamar al 711. Las horas de atención son de 6:00 a.m. a 6:00 p.m., de lunes a viernes.*
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 https://www.regence.com/web/regence_individual/privacy-practices

General Medical Exclusions

	Coverage is not provided for any of the following, including direct complications or consequences that arise from:
Activity Therapy	Creative arts, play, dance, aroma, music, equine, recreational or similar therapy; sensory movement groups; and wilderness or adventure programs.
Acupuncture	
Applied Behavioral Analysis Therapy	
Assisted Reproductive Technologies	Assisted reproductive technologies (including, but not limited to, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.
Breast Reduction	Except when following a Medically Necessary mastectomy, to the extent required by law, We do not cover breast reductions.
Certain Therapy, Counseling and Training	Educational, vocational, social, image, milieu or marathon group therapy, premarital or marital counseling, Individual Assistance Program (IAP) services, except as provided under the IAP Section, if applicable; job skills or sensitivity training.
Conditions Caused By Active Participation In a War or Insurrection	The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.
Conditions Incurred In or Aggravated During Performances In the Uniformed Services	The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of services in the uniformed services of the United States.
Cosmetic/Reconstructive Services and Supplies	Except to treat a congenital anomaly for members up to age 26, to restore a physical bodily function lost as a result of injury or illness or related to breast reconstruction following a medically necessary mastectomy, to the extent required by law.
Counseling in the absence of illness	Except as required by law, We do not cover counseling in the absence of Illness.
Custodial Care	Except as provided under the Palliative Care benefit in the Policy, We do not cover non-skilled care and helping with activities of daily living.
Dental Services	Except as provided in the Policy, We do not cover Dental Services provided to prevent, diagnose, treat diseases, or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.
Facilities Without a Provider Legally Required to be on Duty	Admission and treatment in a setting where neither a Physician, Practitioner, nor licensed nurse is legally required to be on duty at all times that a patient is admitted.

Family Counseling	Except when family counseling is part of the treatment for a child or adolescent with a covered diagnosis, we do not cover family counseling.
Fees, Taxes, Interest	Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.
Government Programs	Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the Service Area (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).
Hearing Care	Routine hearing examinations, programs or treatment for hearing loss including hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.
Hypnotherapy and Hypnosis Services	Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, mental health conditions, substance use disorders or for anesthesia purposes.
Illegal Services, Substances and Supplies	Services, substances and supplies that are illegal as defined under state or federal law.
Individualized Education Program (IEP)	Services or supplies, including, but not limited to, supplementary aids and supports as provided under an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.
Infertility	Treatment of infertility, except to the extent covered services are required to diagnose such condition. Non-covered treatment includes, but is not limited to, surgery, fertility drugs and medications.
Investigational Services	Except as provided under the Approved Clinical Trials benefit in the Policy, We do not cover Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol.

Motor Vehicle Coverage and Other Insurance Liability	Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), or automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Coordination of Benefits provision of the Policy shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Member, whether or not the Member makes a claim under such coverage. Further, the Member is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, We will provide benefits according to the Policy.
Non-Direct Patient Care	Including appointments scheduled and not kept ("missed appointments"), charges for preparing or duplicating medical reports and chart notes, itemized bills or claim forms (even at Our request) and visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as provided under the Telehealth and Telemedicine benefits.
Obesity or Weight Reduction/Control	Except as provided in the Policy or as required by law, We do not cover medical treatment, medications, surgical treatment (including treatment of complications, revisions and reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions. This exclusion does not apply to reversals or revisions of surgery for obesity when required to correct a life-endangering condition. This exclusion also does not apply to treatment of obesity-related comorbid medical conditions; for example: diabetes, high blood pressure and heart disease.
Orthognathic Surgery	Services and supplies for orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to an Injury, sleep apnea, or Congenital Anomaly.
Over the Counter Contraceptives	Except as provided under the Prescription Medications benefit or as required by law, We do not cover over-the-counter contraceptive supplies.
Personal Comfort Items	Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes.
Physical Exercise Programs and Equipment	Including hot tubs or membership fees at spas, health clubs, or other such facilities. This exclusion applies even if the program, equipment, or membership is recommended by the member's provider.
Private Duty Nursing	Private-duty nursing, including ongoing shift care in the home.
Reversal of Sterilizations	Services and supplies related to reversal of sterilization.

Riot, Rebellion and Illegal Acts	Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection, or rebellion or sustained by a member arising directly from an act deemed illegal by an officer or a court of law.
Routine Foot Care	
Self-Help, Self-Care, Training, or Instructional Programs	Self-help, non-medical self-care, training programs, including: childbirth-related classes including infant care; and instruction programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member. This exclusion does not apply to services for training or educating a Member when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service in the Policy (for example, nutritional counseling and diabetic education).
Services and Supplies Provided by a Member of Your Family	Services and supplies provided to you by a member of your immediate family. For purposes of this provision, "immediate family" means you and your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings; your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings; your child's or stepchild's spouse or domestic partner; and any other of your relatives by blood or marriage who shares a residence with you.
Services and Supplies That Are Not Medically Necessary	Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury, except for preventive care benefits specifically provided in the Policy.
Sexual Dysfunction	Except for covered mental health conditions, we do not cover treatment, services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.
Sexual Reassignment Surgery (Including Reversals)	
Temporomandibular Joint (TMJ) Disorder Treatment	Services and supplies provided for temporomandibular joint (TMJ) disorder treatment.
Third-Party Liability	Services and supplies for treatment of illness or injury for which a third party is or may be responsible.
Tobacco Addiction Treatment	Except as specifically provided in the Policy, We do not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes
Travel and Transportation Expenses	Travel and transportation expenses other than covered ambulance services or as otherwise specifically provided in the Policy.
Varicose Vein Treatment	Except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins, we do not cover treatment of varicose veins.

Vision Care	Except as provided in the Policy we do not cover routine eye exam and vision hardware. We also do not cover visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.
Work-Related Conditions	Expenses for services and supplies incurred as a result of any work-related injury or illness, including any claims that are resolved related to a disputed claim settlement. We may require you or one of your eligible dependents to file a claim for workers' compensation benefits before providing any benefits under the Policy. We do not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if you or one of your eligible dependents are exempt from state or federal workers' compensation law.

General Pharmacy Exclusions

Biological Sera, Blood, or Blood Plasma	
Brand-Name Medications not on the Essential Formulary	Except as provided through the Substitution Process in the Prescription Medications benefit, We do not cover Prescription Medications for Brand-Name Medications that are not on the Essential Formulary list.
Cosmetic Purposes	Prescription medications used for cosmetic purposes including removal, inhibition or stimulation of hair growth, retardation of aging or repair of sun-damaged skin.
Devices or Appliances	Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Durable Medical Equipment benefit).
Foreign Prescription Medications	Except those associated with an emergency medical condition while you are traveling outside the United States, or those you purchase while residing outside the United States. We do not cover Foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.
Insulin Pumps and Pump Administration Supplies	Coverage for insulin pumps and supplies is provided under the Diabetes Supplies and Equipment benefit.
Medications We Don't Consider Self-Administrable	Coverage for these medications may otherwise be provided under the Medical Benefits Section.
Nonprescription Medications	Except for medications included on our Essential Formulary, approved by the FDA or a Prescription Order by a Physician or Practitioner, we do not cover medications that by law do not require a Prescription Order, including vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements.
Prescription Medications Dispensed in a Facility	Prescription medications dispensed to you while you are a patient in a hospital, skilled nursing facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.

Prescription Medications For Treatment of Infertility	
Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order	
Prescription Medications Not within a Provider's License	Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.
Prescription Medications Used for Sexual Dysfunction or Enhancement	
Prescription Medications Without Examination	Except as provided under the Telehealth and Telemedicine benefits in this Medical Benefits Section, we do not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe 1) an opioid antagonist to a Member who is at risk of experiencing an opiate-related overdose; or 2) an epinephrine auto-injector to a Member who is at risk of experiencing anaphylaxis.
Professional Charges for Administration of Any Medication	
Travel Immunizations	Immunizations for the purposes of travel, occupation or residency in a foreign country.

General Pediatric Dental Exclusions

Adjustments	Adjustment of a denture or bridgework which is done within 6 months after insertion by the same Dentist who installed the denture or bridgework.
Aesthetic Dental Procedures	Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth.
Bone Grafts	Bone grafts done in connection with extractions, apicoectomies or non-covered/ineligible implant.
Cone Beam Imaging/MRI Procedures	
Cosmetic/Reconstructive Services and Supplies	Cosmetic and/or reconstructive services and supplies, except for Dentally Appropriate services and supplies to treat a Congenital Anomaly and to restore a physical bodily function lost as a result of Injury or Illness.
Decay Prevention	Supplies and materials to prevent decay, such as toothpaste, fluoride gels, dental floss, and teeth whiteners.
Duplicate Services	Services submitted by a Dentist which are for the same services performed on the same date for the same Member by another Dentist.
Experimental or Investigational Services	
Fabrication of Athletic Mouth Guard	
Facility Expenses	Services and supplies related to facility expenses, including, but not limited to: those performed by a Dentist who is compensated by a facility for similar Covered Services performed for Member; and costs or any additional fees that the Dentist or Hospital charges for treatment at the Hospital (inpatient or outpatient).
Failure to Comply	Services and supplies resulting from Your failure to comply with professionally prescribed treatment.
Gold-Foil Restorations	
Nitrous Oxide	
Oral Hygiene and Dietary Instructions	
Oral Sedation	

Orthodontic Dental Services	Except when Dentally Appropriate, We will not cover services and supplies provided in connection with orthodontics, including the following: correction of malocclusion; craniomandibular orthopedic treatment; other orthodontic treatment; preventive orthodontic procedures; procedures for tooth movement, regardless of purpose; and repair of damaged orthodontic appliances.
Plaque Control Programs	
Precision Attachments, Precious Metal Bases and Other Specialized Techniques	
Provisional, Temporary and Duplicate Devices or Appliances	
Replacements	Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.
Sealants	Except as provided for permanent molars.
Separate Charges	Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following: any supplies; local anesthesia; and sterilization (office infection control charges).
Services and Supplies to Alter Vertical Dimension and/or Restore or Maintain the Occlusion	Services and supplies to alter vertical dimension and/or restore or maintain the occlusion, including the following: equilibration; periodontal splinting; full mouth rehabilitation; and restoration for misalignment of teeth.
Services and Supplies Which the Insured Would Have No Legal Obligation to Pay in the Absence of this Coverage	
Services Provided by Certain Entities	Services and treatment received from a Dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration Hospital or similar person or group.
Specialized Procedures and Techniques	
Temporomandibular Joint (TMJ) Disorder Treatment	Services and supplies provided in connection with temporomandibular joint (TMJ) disorder.
Topical Medicament Center	

This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. For full coverage provisions, refer to the contract.

DISCRIMINATION IS AGAINST THE LAW

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, 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, contact us at 888-344-6347.

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 at M/S CS B32B, P.O. Box 1271, Portland, OR 97207-1271, phone: 888-344-6347, TTY: 711, email: CS@regence.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you. 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN OTHER LANGUAGES

The following translations help people who do not read English understand their rights and responsibilities and who to call for help. Including these translations is a federal requirement for all health plans sold on the state or federal marketplaces.

Spanish: Este aviso tiene información importante. Regence cumple con las leyes de derechos civiles federales aplicables y no discrimina sobre la base de raza, color, nacionalidad, edad, discapacidad o sexo. Este aviso tiene información importante sobre su solicitud o cobertura. Busque las fechas importantes en este aviso. Es posible que tenga que tomar alguna acción en un determinado plazo para mantener su cobertura de salud o ayuda con los costos. Usted tiene derecho a obtener esta información y otra información sobre su solicitud o cobertura, en su propio idioma y sin costo. Llame al 888-344-6347. (TTY: 711)

Chinese Traditional: 本通知含有重要資訊。Regence 遵守適用之聯邦政府民權法，不會因種族、膚色、原始出生國籍、年齡、身心障礙或性別的不同而予以差別待遇。本通知含有有關您申請或進行承保的重要資訊。請留意本通知內的重要日期。請在期限之前採取行動，以確保您的醫療保障或協助支付費用。您有權索取使用您語言撰寫的這類資訊，以及有關您申請或承保的相關資訊。請撥打 888-344-6347 索取。（聽障專線：711）

Vietnamese: Thông báo này có Thông tin Quan trọng. Regence tuân thủ luật pháp Liên bang về quyền công dân hiện hành và không phân biệt đối xử theo chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật hoặc giới tính. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Quý vị có quyền lấy thông tin này và thông tin khác về đơn đăng ký hoặc bảo hiểm, bằng ngôn ngữ của mình miễn phí. Gọi số 888-344-6347. (TTY: 711)

Korean: 이 공지 사항에는 중요 정보가 들어 있습니다. Regence은 해당 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 따라 차별하지 않습니다. 이 공지 사항에는 해당 신청서 또는 적용 범위에 관한 중요한 정보가 있습니다. 이 공지 사항의 주요 날짜를 찾아 보십시오. 해당 건강 보험을 그대로 유지하거나 비용을 지원 받으려면 특정 기한까지 조치를 취하셔야 합니다. 귀하는 모국어로 작성된 본 정보나 해당 신청서 또는 보장 범위에 대한 기타 정보를 무료로 받을 수 있는 권리가 있습니다. 888-344-6347로 연락하십시오. (TTY: 711)

Russian: В данном Уведомлении содержится важная информация. Regence несет обязательства по соблюдению применимых норм федерального законодательства о гражданских правах и не допускает дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, статуса инвалидности или пола. В данном уведомлении содержится важная информация о вашем заявлении или страховом покрытии. Обратите внимание на ключевые даты, указанные в данном уведомлении. Возможно, вам нужно предпринять некоторые действия к определенному сроку, чтоб сохранить страховое покрытие или получить помощь с расходами. Вы имеете право получить данную, а также прочую информацию о вашем заявлении или страховом покрытии на родном языке бесплатно. Позвоните по номеру 888-344-6347. (TTY: 711)

Tagalog: Ang Abiso na ito ay may Mahalagang Impormasyon. Ang Regence ay sumusunod sa mga naaangkop na Pederal na batas sa mga karapatang sibil at hindi nagdidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan, o kasarian. Ang abiso na ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o coverage. Hanapin ang mga importanteng petsa sa abiso na ito. Maaaring kailangan mong gumawa ng hakbang hanggang sa mga partikular na takdang araw upang mapanatili mo ang iyong coverage sa kalusugan o tulong sa mga gastusin. May karapatan kang makuha ang impormasyong ito, at iba pang impormasyon tungkol sa iyong aplikasyon o coverage, sa iyong sariling wika nang walang bayad. Tumawag sa 888-344-6347. (TTY: 711)

Ukrainian: Це повідомлення містить важливу інформацію. Regence дотримується застосовного федерального законодавства про громадянські права та не проводить політику дискримінації за расовою приналежністю, кольором шкіри, походженням, віком, інвалідністю та статевою ознакою. Це повідомлення містить важливу інформацію про пов'язану з вами програму або страхове покриття. Зверніть увагу на ключові дати в цьому повідомленні. Щоб зберегти за собою план медичного страхування або право отримувати грошову допомогу, можливо, вам потрібно буде вжити відповідні заходи, для яких установлено певні часові обмеження. Ви маєте право на безкоштовне отримання рідною мовою як цієї інформації, так і будь-якої іншої, пов'язаної з програмою чи страховим покриттям. Телефонуйте за таким номером: 888-344-6347 (телетайп: 711).

Mon-Khmer, Cambodian: សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ ។ Regence អនុលោមទៅតាមច្បាប់របស់សហព័ន្ធស្តីពីសិទ្ធិពលរដ្ឋ ហើយមិនមានការរើសអើងចំពោះពូជសាសន៍ ពណ៌សម្បុរ សញ្ជាតិដើម អាយុ ពិការភាព ឬភេទឡើយ ។
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ស្តីអំពីពាក្យសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ។
សូមរកមើលកាលបរិច្ឆេទសំខាន់ៗក្នុងសេចក្តី ជូនដំណឹងនេះ ។ អ្នកអាចត្រូវចាត់វិធានការឲ្យបានត្រឹមកាលបរិច្ឆេទកំណត់ ដើម្បីរក្សាបាននូវការធានារ៉ាប់រងសុខភាព ឬបានទទួលការជួយចេញការចំណាយថ្លៃថែទាំសុខភាពរបស់អ្នក ។
អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ និងព័ត៌មានដទៃ អំពីពាក្យសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ជាភាសាដែលអ្នកប្រើ ដោយមិនបាច់បង់ប្រាក់ឡើយ ។ ហៅមកលេខ 888-344-6347 ។ (អ្នកពិបាកស្តាប់ ឬពិបាកនិយាយដែលប្រើ TTY សូមហៅមកលេខ ៖ 711)

Japanese: このお知らせには大変重要な情報が含まれています。Regence は、適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、身体障害、性別による差別をしません。このお知らせには保険の申請と適用に関する重要な情報が含まれています。このお知らせに記載されている重要な日付にご注意ください。健康保険適用や医療費支援を引き続き受けるためには締切日までに手続きを行う必要があります。あなたにはこのお知らせおよび申請と保険適用に関するその他の情報について、無料かつ母国語で知る権利があります。こちらまでお電話ください: 888-344-6347。(TTY: 711)

Amharic: ይህ ማሳሰቢያ ጠቃሚ መረጃ ይዟል። Regence በሚተገበረው የፌደራል ሲቪል መብቶች ህግጋት በዘር፣ በቀለም፣ በመጡበት ብሄር፣ እድሜ፣ የአካል ጉዳት ወይም ፆታ መድሎ አይደረግም። ማሳሰቢያው ስለ ማመልከቻዎትና ሽፋን ጠቃሚ መረጃ አለው። በዚህ ማሳሳቢያ ላይ ቁልፍ ቀናትን ይፈልጉ። በተወሰኑ የመጨረሻ ቀናት የጤና ሽፋኑ ላይ ወይም የወጪን ድጋፍ እንዲቀጥል እረምጃ መውሰድ ያስፈልጋል። ይህንን መረጃ እንዲሁም በማመልከቻዎት ወይም ሽፋኑ ላይ ሌሎችንም መረጃዎች በራስዎን ቋንቋ ያለምንም ክፍያ የማግኘት መብት አሎት። 888-344-6347 ይደውሉ። (ቲቲዋይ፡- 711)

Cushite/Oromo: Beeksisni kun odeeffannoo barbaachisaa qabatee jira. Regence Ulaagaa seera mirga Siivilii Federaalaa kan guutuu fi sanyii, bifa, lammummaa, umrii, miidhama qaamaa ykn saala irratti hundaa'ee addaan hinqoodne dha. Beeksisni kun iyyannoo ykn haguuggii kara keessan irratti odeeffannoo barbaachisaa qabatee jira. Guyyoota furtuu beeksisa kana keessa jiran ilaalaa. Haguuggii fayyaa ykn gargaarsa keessan eeggachuuf hanga dhuma yeroo ta'eetti tarkanfii ta'e gatii bastanii fudhachuu qabdu. Odeeffannoo kana fi waa'ee iyyannoo ykn haguuggii keessanii kaffaltii tokko malee afaan keessaniin argachuuf mirga qabdu. Bilbilaa 888-344-6347. (TTY: 711)

Arabic:

يحتوي هذا الإخطار على معلومات مهمة. تمتثل Regence إلى قوانين الحقوق المدنية الفيدرالية المعمول بها ولا تمارس التمييز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة أو الجنس. يحتوي هذا الإخطار على معلومات مهمة عن الطلب أو التغطية الخاصة بك. ابحث عن التواريخ الرئيسية في هذا الإخطار. فقد تحتاج إلى اتخاذ إجراء ما قبل بعض المواعيد النهائية للحفاظ على التغطية الصحية الخاصة بك أو تلقي مساعدة بخصوص التكاليف. لديك الحق في الحصول على هذه المعلومات والمعلومات الأخرى المتعلقة بالطلب أو التغطية الخاصة بك بلغتك مجانًا. اتصل بالرقم 888-344-6347. (الكتابة عن بُعد للصم: 711)

Punjabi: ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। Regence ਲਾਗੂ ਫੈਡਰਲ ਨਾਗਰਿਕ ਅਧਿਕਾਰਾਂ ਦੇ ਕਨੂੰਨ ਦੇ ਅਨੁਰੂਪ ਹੈ ਅਤੇ ਜਾਤਿ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਪਾਹਿਜਤਾ, ਜਾਂ ਲਿੰਗ ਦੇ ਅਧਾਰ 'ਤੇ ਭੇਦਭਾਵ ਨਹੀਂ ਕਰਦਾ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਤੁਹਾਡੇ ਬੇਨਤੀ-ਪੱਤਰ ਅਤੇ ਸੁਰੱਖਿਆ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮੁੱਖ ਮਿਤੀਆਂ ਵੇਖੋ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਸਿਹਤ ਸੁਰੱਖਿਆ ਰੱਖਣ ਜਾਂ ਲਾਗਤਾਂ ਨਾਲ ਮਦਦ ਕਰਨ ਲਈ ਨਿਯਤ ਮਿਆਦ ਸੀਮਾਵਾਂ ਦੁਆਰਾ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ। ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ, ਅਤੇ ਆਪਣੇ ਬੇਨਤੀ ਪੱਤਰ ਜਾਂ ਸੁਰੱਖਿਆ ਬਾਰੇ ਹੋਰ ਜਾਣਕਾਰੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। 888-344-6347 'ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

German: Diese Mitteilung enthält wichtige Informationen. Regence hält die Grundrechte der USA ein und es finden keine Diskriminierungen aufgrund von Rasse, Hautfarbe, nationaler Herkunft, Alter, Behinderung oder Geschlecht statt. Diese Mitteilung enthält wichtige Informationen über Ihren Antrag oder die entsprechende Versicherungsdeckung. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Sie haben das Recht, diese Informationen und andere Informationen über Ihren Antrag oder Ihren Versicherungsschutz kostenlos in Ihrer Sprache zu erhalten. Rufen Sie folgende Nummer an 888-344-6347. (Fernschreiber: 711)

Laotian: ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສຳຄັນ. Regence ສອດຄ່ອງກັບກົດໝາຍ ວ່າດ້ວຍ ສິດທິພົນລະເມືອງຂອງຣັຖບານກາງ ທີ່ກ່ຽວຂ້ອງ ແລະ ບໍ່ມີການຈຳແນກ ເຊື້ອຊາດ, ສີຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມເປັນຄົນພິການ ຫຼື ເພດ. ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການນຳໃຊ້ຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງ. ຊອກຫາວັນທີທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງການດຳເນີນການໃນຂອບເຂດເວລາໃດຫຼຶ່ງ ເພື່ອ ໃຫ້ສືບຕໍ່ໄດ້ຮັບການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ທ່ານມີສິດເອົາຂໍ້ມູນນີ້ ແລະ ຂໍ້ມູນອື່ນ ກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕິດຕໍ່ 888-344-6347. (TTY: 711)