



Regence BlueCross BlueShield of Utah  
 is an Independent Licensee of the BlueCross and BlueShield Association

# Washington County School District Medical Plan: BluePoint ValueCare Network

Effective August 1, 2018 through July 31, 2019

	In-Network Provider What You Pay	Out-of-Network Provider What You Pay
<b>Annual Costs</b>		
Coinsurance	20%	40%
Deductible per Plan Year	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
Out-of-Pocket Maximum per Plan Year	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
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.		
<b>Medical Services</b>		
<i>Unless stated otherwise, a deductible applies</i>		
Primary Care (for illness or injury)	\$30 copay per visit	40%
Specialist	\$60 copay per visit	40%
Urgent Care	\$60 copay per visit	40%
Other Professional Services	20%	40%
Preventive Care/Immunizations <ul style="list-style-type: none"> <li>Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA).</li> <li>Childhood Immunizations covered at no cost.</li> </ul>	0% coinsurance, deductible waived	40%
Ambulance Services	20%	20 %
Emergency Room (Including Professional Charges)	\$325 copay per visit, not subject to deductible, 0% coinsurance	
Genetic Testing	20% coinsurance	40%
Home Health Care <ul style="list-style-type: none"> <li>Unlimited</li> </ul>	20%	40%
Hospice Care <ul style="list-style-type: none"> <li>Limit: 14 inpatient or outpatient respite care days per lifetime</li> </ul>	20%	40%
Hospital Care <ul style="list-style-type: none"> <li>Infertility Diagnosis and Treatment only \$5,000 limit per Plan Year</li> </ul>	50%	Not Covered
Maternity Care/Adoption Benefit <ul style="list-style-type: none"> <li>Adoption Limit: \$4,000 per pregnancy</li> </ul>	20%	40%
Mental Health/Substance Use Disorder Therapy Services – Inpatient	20%	40%
Mental Health/Substance Use Disorder Therapy Services – Outpatient	\$30 copay per visit	40%
Nutritional Counseling <ul style="list-style-type: none"> <li>Limit: 3 visits per lifetime</li> </ul>	20%	40%
Palliative Care <ul style="list-style-type: none"> <li>Limit: 30 visits per Plan Year</li> </ul>	20%	40%

	In-Network Provider What You Pay	Out-of-Network Provider What You Pay
Radiology and Laboratory – Outpatient X-ray, Blood Work	0% coinsurance, deductible waived	40%
Radiology-Outpatient CT/PET Scans/MRI	20%	40%
Rehabilitation Services -Inpatient • Limit: 40 days per Plan Year	20%	40%
Rehabilitation Services- Outpatient • Limit: 60 visits per Plan Year	\$60 copay, deductible waived, 0% coinsurance	40%
Skilled Nursing Facility (SNF) Care • Limit: 60 inpatient days per Plan Year	20%	40%
Spinal Manipulations • Limit: 15 spinal manipulations per Plan Year	\$60 copay per visit, deductible waived, 0% coinsurance	40%
Telehealth	\$30 copay per visit	Not covered

Prescription Medication Services	
<i>Coverage is limited to a 90-day supply retail or mail order, 30-day for Specialty. Unless stated otherwise, a deductible applies.</i>	
Individual Deductible per Plan Year	\$100 (calculated separately from your medical deductible)
Generic	\$10 copay retail prescription \$10 copay mail order prescription
Preferred Brand	\$25 copay retail prescription \$50 copay mail order prescription
Nonpreferred Brand	\$45 copay retail prescription \$135 copay mail order prescription
Specialty	\$100 copay

Please note: This benefit summary provides a brief description or illustration of your health care plan benefits, limitations and/or exclusions under your health care plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at our website, [regence.com](http://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.

1 (866) 240-9580 - TTY: 711  
MS CS B32B, PO Box 1827 Medford, OR 97501-9884  
[regence.com](http://regence.com)

## 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。

**Dii baa akó ninizin:** Dii saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éi ná hóló, koji' hódíilnih 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.

**ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយវិទ្យាសាស្ត្រភាសាដោយមិនគិតល្អ្លល 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 አርዳታ ድርጅቶች፣ በገጻ ሊያገለግሉት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (ማስማት 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 नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिपिवाइ: 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)

**ប្រែក្រាប:** ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ, ការជំនួយភាសាដោយមិនគិតល្អ្លល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)

**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 فذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)