Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

SDIS SPECIAL DISTRICTS INSURANCE SERVICES

SDIS HSA Plan

Effective July 1, 2020 through June 30, 2021

Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per Calendar year	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	$6,000 Individual $12,000 Family	$7,000 Individual $14,000 Family

The In-Network Out-of-Pocket Maximum for any Member on Family Coverage is not to exceed $6,580, including the In-Network Deductible. If a Member reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, including the In-Network Deductible, benefits will be paid at 100% of the Allowed Amount for that Member.

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	
Primary Care Visits (for Illness or Injury)		20% coinsurance	50% coinsurance
Specialist Visits		20% coinsurance	50% coinsurance
Urgent Care Visits		20% coinsurance	50% coinsurance
Other Professional Services		20% coinsurance	50% coinsurance
Preventive Care/Immunizations		0%, deductible waived	50% coinsurance
Acupuncture and Chiropractic Spinal Manipulations	• Chiropractic spinal manipulations and acupuncture services from any licensed provider • $1,500 limit per Calendar year	20% coinsurance	50% coinsurance
Ambulance Services		Ground: 20% coinsurance Air: 50% coinsurance	Ground: 20% coinsurance Air: 50% coinsurance
Ambulatory Surgical Center		20% coinsurance	50% coinsurance
Emergency Room (Including Professional Charges)		20% coinsurance	20% coinsurance
Hearing Aids & Evaluations		20% coinsurance	50% coinsurance
Hearing Examinations	• Limit: 1 exam per Calendar year	20% coinsurance	50% coinsurance
Home Health Care	• Limit: 130 visits per Calendar year	20% coinsurance	50% coinsurance
Hospice Care	• Limit: 30 inpatient or outpatient respite care days per lifetime	20% coinsurance	50% coinsurance
Hospital Care		20% coinsurance	50% coinsurance
Maternity Care		20% coinsurance	50% coinsurance
Mental Health/Substance Use Disorder - Inpatient		20% coinsurance	50% coinsurance
Mental Health/Substance Use Disorder - Outpatient		20% coinsurance	50% coinsurance
Neurodevelopmental Therapy - Outpatient	• Limit: 30 visits per Calendar year • Children up to the age of 18	20% coinsurance	50% coinsurance
Nutritional Counseling	• Limit: 5 visits per lifetime	20% coinsurance	50% coinsurance
Radiology and Laboratory - Outpatient		20% coinsurance	50% coinsurance
Advanced Imaging	• CT, PET, MRA, SPECT, Bone Density, MRI	20% coinsurance	50% coinsurance

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
Rehabilitation Services - Inpatient	• Limit: 30 days per Calendar year	20% coinsurance	50% coinsurance
Rehabilitation Services - Outpatient	• Limit: 30 visits combined per Calendar year	20% coinsurance	50% coinsurance
Skilled Nursing Facility (SNF) Care	• Limit: 60 days per Calendar year	20% coinsurance	50% coinsurance
Telehealth		20% coinsurance	50% coinsurance

Vision Benefits		What You Pay	
Routine Eye Exam	• Limit: 1 per Calendar year	$25 copay, deductible waived	No charge up to $40
Contact Lens Fitting	• Limit: 1 per Calendar year	No charge	No charge up to $40
Hardware		No charge up to $250 maximum per year	No charge up to $250 maximum per year

Prescription Medication Services	
Your prescription drug coverage is administered through CVS/Caremark, via RxBenefits. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information. *Please contact the RxBenefits Inc member services team at (800) 334-8134 or visit www.Caremark.com for all of your CVS/Caremark prescription drug coverage questions.*	
Generic	20% coinsurance, retail or mail order prescription
Preferred Brand	20% coinsurance, retail or mail order prescription
Nonpreferred Brand	20% coinsurance, retail or mail order prescription
Specialty	20% coinsurance

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.

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