Regence Cascade Silver

Individual Connect

Effective January 1, 2026 through December 31, 2026

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	$2,500 Individual $5,000 Family	Not covered
Annual Prescription Deductible	The total deductible You pay per calendar year for prescription medications	Shared with medical	Not covered
Annual Out-of-Pocket Maximum	The combined total for Your deductible(s), coinsurance and copays per calendar year	$9,750 Individual $19,500 Family	Not covered

10 Essential Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
1. Ambulatory Care	Primary Care (PCP) Visits (for Illness or Injury)	First 2 PCP visits (combined with Acupuncture / Spinal Manipulations / Virtual Care for PCP), $1 copay per visit, deductible waived After first 2 visits, $20 copay per visit, deductible waived	Not covered
	Specialist Visits	$65 copay per visit, deductible waived	Not covered
	Urgent Care Visits	$65 copay per visit, deductible waived	
2. Emergency Care	Emergency Room Care	$800 copay per visit	
	Ambulance	$375 copay per visit, deductible waived	
3. Hospitalization	Hospital Care - Inpatient (copay applies to first 5 days per visit)	$800 copay per day	Not covered
	Supplies	Hospital Care - Inpatient copay applies	Not covered
4. Radiology / Laboratory Services	Radiology / Laboratory - Inpatient	Hospital Care - Inpatient copay applies	Not covered
	Radiology / Laboratory - Outpatient	$65 copay for outpatient diagnostic imaging and x-ray, deductible waived $40 copay for outpatient laboratory and professional services, deductible waived	Not covered
5. Maternity and Newborn Care	Maternity Care	Hospital Care - Inpatient copay applies	Not covered
	Newborn Care	30%	Not covered
6. Mental Health / Substance Use Disorder (MHSUD) Services	Mental Health / Substance Use Disorder - Inpatient	Hospital Care - Inpatient copay applies	Not covered

10 Essential Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	**Out-of-Network**
	Mental Health / Substance Use Disorder - Outpatient	First 2 MHSUD visits (combined with Virtual Care for MHSUD), $1 copy per visit, deductible waived After first 2 visits, $20 copy per outpatient office / psychotherapy visit, deductible waived All other outpatient services - $30 copy per visit, deductible waived	Not covered
7. Rehabilitation / Habilitation Services	Habilitation - Inpatient (30 days per calendar year)	Hospital Care - Inpatient copay applies	Not covered
	Habilitation - Outpatient (25 visits per calendar year)	$40 copay per visit, deductible waived	Not covered
	Rehabilitation - Inpatient (30 days per calendar year)	Hospital Care - Inpatient copay applies	Not covered
	Rehabilitation - Outpatient (25 visits per calendar year)	$40 copay per visit, deductible waived	Not covered
8. Pediatric Services (under age 19)	**Pediatric Dental Care**	Not covered	
	Pediatric Vision Care: Exams - 1 comprehensive routine eye exam per calendar year Contacts - available once per calendar year in lieu of all other lenses / frame benefits Frames - 1 frame per calendar year Lenses - 1 pair of standard lenses per calendar year; includes scratch and UV protection	Covered in full (for routine exam and hardware) Frames - limited to Otis & Piper Eyewear Collection	Not covered
	Find Your vision plan benefits or a VSP vision provider at regence.com or call 1-844-299-3041		
9. Prescription Medications	Generic (deductible waived)	$25 retail prescription* / $75 home delivery prescription	Not covered
	Preferred Brand-Name (deductible waived)	$75 retail prescription* / $225 home delivery prescription	Not covered
	Brand-Name	$250 retail prescription* / $750 home delivery prescription	Not covered
	Specialty	$250 specialty drug	Not covered

**1 copay per 30-day supply*
***Cost Shares** for insulin, certain inhaled asthma medications and epinephrine autoinjectors (per 2 pack) will not exceed $35 per 30-day supply, deductible waived; or $105 90-day supply, deductible waived*
30% for each self-administered Cancer Chemotherapy medication
You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and / or coinsurance
More information about prescription drug coverage is available at https://regence.com/go/2026/WW/4tier

10. Preventive Services - Wellness Rewards available	Annual Physical Exams	Covered in full	Not covered
	Immunizations	Covered in full	Not covered
	Preventive Screenings	Covered in full	Not covered
Other Services	Acupuncture	First 2 visits (combined with PCP Office Visit / Virtual Care for PCP), $1 copay per visit, deductible waived After first 2 visits, $20 copay per visit, deductible waived	Not covered
	Spinal Manipulations (10 spinal manipulation visits per calendar year)		

10 Essential Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
	Virtual Care - Telehealth (doctor visits via phone or video chat when not in a healthcare facility [includes Mental Health visits] - limitations apply)	First 2 PCP visits and first 2 MHSUD outpatient visits (combined with PCP / MHSUD), $1 copay per visit, deductible waived After first 2 PCP visits and first 2 MHSUD outpatient visits, $20 copay per visit, deductible waived	Not covered

Value-Added Services

Your Regence coverage includes access to the value-added services detailed here. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS.** These value-added services may work alongside Your coverage. For additional information regarding any of these value-added services, visit Our website or contact Customer Service.

Individual Assistance Program (IAP)	IAP is short-term, confidential counseling with no Out-of-Pocket expense. (4 mental health counseling visits per issue)
Joint, Spine, and Muscle Program	The Joint, Spine, and Muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles.
Kidney Health Management	If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD).
Mobile APP	Quick access to: chat with Customer Service, estimate treatment cost, ID card, pay premiums, pharmacy pricing, view claims.
Nurse Advice	You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care 24 / 7. However, if You are experiencing a medical emergency, immediately call 911 instead.
Pregnancy Program	Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions, the Pregnancy Program can help.
Regence Advantages	Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services.
Regence Empower	Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. Wellness Rewards available.

Provider Networks

Your enrolled network is Individual Connect. There are several provider networks in Your state. Please note that these networks are not interchangeable and support different providers. To find providers in Your network, please sign into Your account and use Our provider search tool: https://regence.com/go/WW/IndividualConnect.

Out-of-Area Services

Outside the service area in Washington State, Insureds have In-Network benefits for all Covered Services at Blue Cross and / or Blue Shield (Blue Plan) facilities across the State. Outside of the service area, Insureds have In-Network benefits for Ambulance, Emergency Room and Urgent Care only, in addition to approved Out-of-Network coverage. Additionally, Insureds will receive In-Network benefits at Blue Cross and / or Blue Shield (Blue Plan) Urgent Care facilities across the country through the BlueCard® Program and worldwide through the Blue Cross Blue Shield Global® Core program. No other services are covered worldwide. Out-of-Network, You may be balance billed. Call 1-800-810-BLUE (2583) to learn how to get access.

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.
Is there a cost for “Covered in full”?	No, if Your benefit is covered in full there is no copay or deductible up to the plan limit.
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 key utilization management (UM) process does the plan use?	Utilization management is the way We review the type and amount of care You receive and includes pre-service (prior authorization), concurrent review (including urgent concurrent review), and post-service review. You can find more information online at www.regence.com/go/um.

Definitions

Allowed Amount: The lower price an In-Network provider has agreed to accept as payment in full for the care provided to You.

Balance Billing: The difference between the provider's charge and what Your plan pays.

Coinsurance: Your share of the cost for care after You pay any deductible. It's usually a percentage of the total cost of care (for example, 20%).

Copay: A flat dollar amount You pay for care, like a doctor's visit, hospital outpatient visit or prescription. You will usually pay it when You go in for care.

Deductible: The amount You pay out of Your own pocket each calendar year before Your plan begins to pay. Some services, such as preventive care, are sometimes covered at 100% before You have met Your deductible.

Drug List (also known as a formulary): A list of prescription medications that Your plan covers. It includes brand-name, generic and specialty drugs.

Exclusive Provider Organization Networks (EPOs): EPOs cover only In-Network care. This means You are responsible for 100% of the costs of any Out-of-Network care (excluding emergency services). To avoid surprise bills, You must be careful to always see an In-Network provider.

Explanation of Benefits (EOB): A statement that explains how much Regence paid toward a claim and how much You owe the provider for care.

Generic Drugs: A prescription medication approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name version. Generally, a generic drug works the same as a brand-name drug and usually costs less.

In-Network Provider: A facility or health professional contracted with Your plan. You usually have lower Out-of-Pocket costs when You use In-Network providers.

Out-of-Network Provider: A facility or health professional not contracted with Your plan. You usually have higher Out-of-Pocket costs when You use Out-of-Network providers.

Out-of-Pocket Maximum: The most You will have to pay in deductible, coinsurance and copays per calendar year. Once You have met this maximum, Regence pays 100% of Your covered care for the rest of the calendar year.

Primary Care Provider (PCP): A doctor or other health professional You see as the first point of contact for medical care and Your partner in managing Your health care.

Specialist: An expert in a particular area of medicine, for example, a dermatologist, allergist or cardiologist.

Telehealth: Care that You receive from a doctor over the phone or computer for routine needs and ailments.

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 policy online at regence.com. **PLEASE REFER TO YOUR BENEFITS POLICY 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.

Customer Service: 1-855-857-9959 - TTY: 711 | 1111 Lake Washington Blvd N., Suite 900, Renton, WA 98056 | regence.com

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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, sex, sexual orientation or gender identity, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

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。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' 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. 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)