



Cost Share Details		In-Network	Out-of-Network
Annual Medical Deductible	The total deductible you pay per calendar year	\$4,750 Individual \$9,500 Family	\$7,500 Individual \$15,000 Family
Annual Prescription Deductible	The total deductible you pay per calendar year for prescription medications	Shared with medical	
Annual Out-of-Pocket Maximum	The combined total for your deductible(s), coinsurance and copays per calendar year	\$7,700 Individual \$15,400 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.

Medical Benefits <i>(unless stated otherwise, a deductible applies)</i>		What You Pay	
		In-Network	Out-of-Network
Primary Care Visits (for Illness or Injury)		\$40 copay per visit, deductible waived	50%
Specialist Visits		\$60 copay per visit, deductible waived	50%
Urgent Care Visits		\$60 copay per visit, deductible waived	50%
Other Professional Services		35%	50%
Preventive Care / Immunizations	Preventive Employee Wellness Incentives available	Covered in full	50%
Radiology and Laboratory - Outpatient		35%	50%
Complex Imaging - Outpatient	CT / PET / SPECT scans, MRIs, MRAs, etc.	35%	50%
Acupuncture	12 visits per calendar year	\$40 copay per visit, deductible waived	50%
Ambulance Services	Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment	35%, In-Network deductible applies	
Ambulatory Surgical Center		25%	50%
Emergency Room	Facility and professional services	\$400 copay per visit, In-Network deductible applies	
Hearing Aids and Evaluation	1 hearing aid per ear every 36 months Excludes routine hearing exams, television caption decoder and cords	35%	50%
Hospital Care - Inpatient	\$3,500 per day for inpatient non-emergency admissions to Out-of-Network facilities	35%	50%
Hospital Care - Outpatient	See Ambulatory Surgical Center for cost reduction option	35%	50%
Mental Health / Substance Use Disorder - Inpatient	\$3,500 per day for inpatient non-emergency admissions to Out-of-Network facilities	35%	50%
Mental Health / Substance Use Disorder - Outpatient	In addition to this benefit, see Employee Assistance Program option	\$40 copay per outpatient office / psychotherapy visit, deductible waived	50%
Rehabilitation Services - Inpatient	30 days per calendar year (up to 60 days for head or spinal cord injury) \$3,500 per day for inpatient non-emergency admissions to Out-of-Network facilities	35%	50%
Rehabilitation Services - Outpatient	30 visits per calendar year	\$40 copay per visit, deductible waived	50%

Medical Benefits <i>(unless stated otherwise, a deductible applies)</i>		What You Pay	
		In-Network	Out-of-Network
Skilled Nursing Facility	60 days per calendar year	35%	50%
Spinal Manipulations	20 visits per calendar year	\$40 copay per visit, deductible waived	50%
Virtual Care - Store and Forward	Asynchronous (not real-time) communications such as text or fax	\$10 copay per visit, deductible waived	50%
Virtual Care - Telehealth	Doctor visits via phone or video chat when <u>not</u> in a healthcare facility (includes Mental Health visits)	\$10 copay per visit, deductible waived	50%
Virtual Care - Telemedicine	Doctor visits via phone or video chat when in a healthcare facility	35%	50%

Pediatric Benefits - Dependents Under Age 19 <i>(unless stated otherwise, a deductible applies)</i>		What You Pay	
		In-Network	Out-of-Network
Dental Care - Preventive	Cleanings - 2 per calendar year with a 3 rd being covered with qualifying diagnosis Fluoride Treatment, Oral Exams - 2 per calendar year Sealants - 1 per permanent molar every 5 calendar years X-rays - 1 set per calendar year		Covered in full
Dental Care - Basic	Emergency / Palliative Treatment - emergency pain relief Endodontics - such as root canal Fillings - composite and amalgam restorations Oral Surgery - includes removal of teeth and surgical extractions Periodontal Maintenance - 2 per calendar year Scaling and Root Planing - 1 per 2 calendar years		20%, deductible waived
Dental Care - Major	Crowns, Inlays, Onlays - covered with limitations Dentures (full or partial), Bridges (fixed partial denture) - repairs, rebase, and relines covered with limitations Pediatric Dental network: Regence Dental Network		50%, deductible waived
Vision Care	Exam - 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 Find your vision plan benefits or a VSP vision provider at regence.com or call 1 (844) 299-3041	\$0 copay, deductible waived Frames - limited to Otis & Piper Eyewear Collection	50%, deductible waived Frames - no restrictions on frame selection

Prescription Medication Benefits <i>(unless stated otherwise, a deductible applies)</i>		What You Pay	
Preferred Generic	Deductible waived 90-day supply for retail or home delivery (mail-order)	\$25 retail prescription* / \$75 home delivery (mail-order) prescription	
Generic	Deductible waived 90-day supply for retail or home delivery (mail-order)	\$35 retail prescription* / \$105 home delivery (mail-order) prescription	
Preferred Brand	Deductible waived 90-day supply for retail or home delivery (mail-order)	\$60 retail prescription* / \$180 home delivery (mail-order) prescription	
Brand	Deductible waived 90-day supply for retail or home delivery (mail-order)	50% retail prescription / 50% home delivery (mail-order) prescription	
Preferred Specialty	30-day supply for retail	20% 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 or home delivery (mail-order): \$80 cap on member cost share per 30-day supply, deductible waived; \$240 cap on member cost share up to 90-day supply, deductible waived
35% 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/2023/OR/6tier>

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.** For additional information regarding any of these value-added services, visit Our Web site or contact Customer Service.

Employee Assistance Program (EAP)	EAP is short-term, confidential counseling with no out-of-pocket expense. (4 mental health counseling visits per issue) Contact Crisis Counseling hotline directly at 1 (866) 750-1327
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: ID card, chat with Customer Service, View Claims, Estimate Treatment Cost, Pharmacy pricing
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, call 1 (888) JOY-BABY (569-2229)
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

Out-of-Area Services

Outside of the service area, members have In-Network benefits at Blue Cross and / or Blue Shield (Blue Plan) facilities across the country through the BlueCard® Program and worldwide through the BlueCross BlueShield Global™ Core Program. Any other services will not be covered when processed through any Inter-Plan arrangements. 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 .
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.
Is there a cost for "Covered in full"?	No, if your benefit is covered in full there is no copay or deductible.

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.

Customer Service: 1 (888) 367-2116 - TTY: 711 | 100 SW Market Street, Portland, OR 97201 | 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。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 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 ដោយមិនគិតល្អល 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 ሊያገዝዎት ተዘጋጅተዋል፤ 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 (टिडिवाइ: 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, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີຜ້ອມໃຫ້ທ່ານ. ໂທ 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 711 TTY)