



Cost Share Details		Preferred Network	Participating Network	Nonparticipating Network
Annual Deductible	The total deductible you pay per calendar year	\$3,000 Individual \$6,000 Family	Shared with Preferred Network	Shared with Preferred Network
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	\$6,000 Individual \$12,000 Family	Shared with Preferred Network	Shared with Preferred Network

Be aware that your actual costs for Covered Services provided by a Nonparticipating Network provider may exceed the Out-of-Pocket Maximum amount. In addition, Nonparticipating 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)		Preferred Network	Participating Network	Nonparticipating Network
		What You Pay		
Primary Care Visits (for Illness or Injury)		\$30 copay per visit, deductible waived, 20% for all other services	40%	40%
Specialist Visits		\$30 copay per visit, deductible waived, 20% for all other services	40%	40%
Urgent Care Visits		Covered the same as if you visit a health care provider's office or clinic (Primary Care Visit or Specialist Visit) or if you have a test (Radiology and Laboratory or Complex Imaging).		
Other Professional Services		20%	40%	40%
Preventive Care/Immunizations		0%, deductible waived	0%, deductible waived	40%
Radiology and Laboratory - Outpatient		20%, deductible waived	40%, deductible waived	40%, deductible waived
Complex Imaging - Outpatient	CT/PET/SPECT scans, MRIs, MRAs, etc.	20%	40%	40%
Acupuncture & Chiropractic Spinal Manipulations	Chiropractic spinal manipulations and acupuncture services from any licensed provider 16 visits per member per calendar year	20%, deductible waived	20%, deductible waived	20%, deductible waived
Ambulance Services		20%	20%	20%
Ambulatory Surgical Center		10%	40%	40%
Emergency Room (Including Professional Charges) Copay waived if admitted to the hospital		\$150 copay per visit, 20% coinsurance, deductible waived	\$150 copay per visit, 20% coinsurance, deductible waived	\$150 copay per visit, deductible waived, Regence pays 80%, member pays balance of billed charges.
Hearing Aids & Evaluations		20%	40%	40%
Home Health Care	130 visits per calendar year	20%	40%	40%
Hospice Care	14 days of respite care per lifetime	20%	40%	40%
Hospital Care		20%	40%	40%
Mental Health/Substance Use Disorder - Inpatient		20%	20%	40%
Mental Health/Substance Use Disorder - Outpatient		20%, deductible waived	20%, deductible waived	40%, deductible waived
Neurodevelopmental Therapy - Outpatient	25 visits per calendar year Children under the age of 18	20%	40%	40%
Nutritional Counseling	3 visits per lifetime	20%	40%	40%
Palliative Care	30 visits per calendar year	20%	40%	40%
Rehabilitation Services - Inpatient	30 days per calendar year	20%	40%	40%

Medical Benefits (unless stated otherwise, a deductible applies)		Preferred Network	Participating Network	Nonparticipating Network
Rehabilitation Services - Outpatient	30 visits per calendar year	20%	40%	40%
Retail Office Visits	Visits to a walk-in clinic located within a retail operation	\$30 copay per visit, deductible waived	40%	40%
Skilled Nursing Facility (SNF) Care	60 days per calendar year	20%	40%	40%
Spinal Manipulations - Osteopathic		20%	40%	40%
Virtual Care – Store & Forward Services	Asynchronous (not real-time) communications such as text or fax	20%, deductible waived	20%, deductible waived	40%
Virtual Care - Telehealth	Doctor visits via phone or video chat when <u>not</u> in a healthcare facility	20%, deductible waived	20%, deductible waived	40%
Virtual Care - Telemedicine	Doctor visits via phone or video chat when in a healthcare facility	20%	40%	40%

Prescription Medication Benefits (unless stated otherwise, a deductible applies)		What You Pay
Annual Deductible	The total deductible you pay per calendar year	Not applicable
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with medical
Preferred Generic	90-day supply for retail or mail order	\$10 preferred retail prescription / \$20 preferred mail order prescription / \$10 for each self-administrable Cancer Chemotherapy medication
Generic	90-day supply for retail or mail order	\$15 retail prescription / \$30 mail order prescriptions / \$10 for each self-administrable Cancer Chemotherapy medication
Preferred Brand	90-day supply for retail or mail order	\$30 preferred retail prescription / \$60 preferred mail order prescription / \$50 for each self-administrable Cancer Chemotherapy medication
Brand	90-day supply for retail or mail order	\$50 retail prescription / \$100 mail order prescription / \$50 for each self-administrable Cancer Chemotherapy medication
Preferred Specialty	30-day supply for retail	\$150 preferred retail prescription, \$100 for each self-administrable Cancer Chemotherapy medication
Specialty	30-day supply for retail	\$200 retail prescription, \$100 for each self-administrable Cancer Chemotherapy medication

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](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 (888) 367-2116 - TTY: 711 | 100 SW Market Street, Portland, OR 97201 | [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>.

