AGC Health Benefit Trust
Preferred Medical Plan 10 – Rx 1
Effective January 1, 2020 through December 31, 2020

Regence

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

Cost Share Details		Preferred Network	Participating Network	Nonparticipating Network
Annual Deductible	The total deductible you pay per calendar year	$2,500 Individual $5,000 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	$6,850 Individual $13,700 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)		$25 copay per visit, 0%, deductible waived	50%	50%
Specialist Visits		$55 copay per visit, 0%, deductible waived	50%	50%
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		30%	50%	50%
Preventive Care/Immunizations		0%, deductible waived	0%, deductible waived	50%
Radiology and Laboratory - Outpatient		30%, deductible waived	50%, deductible waived	50%, deductible waived
Complex Imaging - Outpatient	CT/PET/SPECT scans, MRIs, MRAs, etc.	30%	50%	50%
Acupuncture & Chiropractic Spinal Manipulations	Chiropractic spinal manipulations and acupuncture services from any licensed provider 16 visits per member per calendar year	30%, deductible waived	30%, deductible waived	30%, deductible waived
Ambulance Services		30%	30%	30%
Ambulatory Surgical Center		20%	50%	50%
Emergency Room (Including Professional Charges) Copay waived if admitted to the hospital		$150 copay per visit, 30% coinsurance, deductible waived	$150 copay per visit, 30% coinsurance, deductible waived	$150 copay per visit, deductible waived, Regence pays 70%, member pays balance of billed charges.
Hearing Aids & Evaluations		30%	50%	50%
Home Health Care	130 visits per calendar year	30%	50%	50%
Hospice Care	14 days of respite care per lifetime	30%	50%	50%
Hospital Care		30%	50%	50%
Mental Health/Substance Use Disorder - Inpatient		30%	30%	50%
Mental Health/Substance Use Disorder - Outpatient		30%, deductible waived	30%, deductible waived	50%, deductible waived
Neurodevelopmental Therapy - Outpatient	25 visits per calendar year Children under the age of 18	30%	50%	50%
Nutritional Counseling	3 visits per lifetime	30%	50%	50%
Palliative Care	30 visits per calendar year	30%	50%	50%
Rehabilitation Services - Inpatient	30 days per calendar year	30%	50%	50%
Rehabilitation Services - Outpatient	30 visits per calendar year	30%	50%	50%

Medical Benefits (unless stated otherwise, a deductible applies)		Preferred Network	Participating Network	Nonparticipating Network
Retail Office Visits	Visits to a walk-in clinic located within a retail operation	$25 copay per visit, deductible waived	50%	50%
Skilled Nursing Facility (SNF) Care	60 days per calendar year	30%	50%	50%
Spinal Manipulations - Osteopathic		30%	50%	50%
Virtual Care – Store & Forward Services	Asynchronous (not real-time) communications such as text or fax	30%, deductible waived	30%, deductible waived	50%
Virtual Care - Telehealth	Doctor visits via phone or video chat when not in a healthcare facility	30%, deductible waived	30%, deductible waived	50%
Virtual Care - Telemedicine	Doctor visits via phone or video chat when in a healthcare facility	30%	50%	50%

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. 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

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。

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 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)