



| Cost Share Details | | In-Network | Out-of-Network |
|--|---|--|---|
| Annual Deductible | The total deductible you pay per calendar year | \$6,000 Individual \$12,000 Family | Shared with In-Network |
| Annual Out-of-Pocket Maximum | The combined total for your deductible, coinsurance and copays per calendar year | \$8,150 Individual \$16,300 Family | Shared with In-Network |
| Be aware that your actual costs for Covered Services provided by a 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) | | In-Network | Out-of-Network |
| Primary Care Visits (for Illness or Injury) | | \$35 copay per visit, deductible waived, 40% for all other services | 50% |
| Specialist Visits | | \$55 copay per visit, deductible waived, 40% for all other services | 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 | | 40% | 50% |
| Preventive Care/Immunizations | | 0%, deductible waived | 50% |
| Radiology and Laboratory - Outpatient | | 40%, deductible waived | 50%, deductible waived |
| Complex Imaging - Outpatient | CT/PET/SPECT scans, MRIs, MRAs, etc. | 40% | 50% |
| Acupuncture & Chiropractic Spinal Manipulations | Chiropractic spinal manipulations and acupuncture services from any licensed provider 16 visits per member per calendar year | \$35 copay / deductible waived | 50% coinsurance, deductible applies |
| Ambulance Services | | 40% | 40% |
| Ambulatory Surgical Center | | 30% | 50% |
| Emergency Room (Including Professional Charges) | | \$200 copay per visit, 40% coinsurance, deductible waived | \$200 copay per visit, 40% coinsurance, deductible waived |
| Copay waived if admitted to the hospital | | | |
| Hearing Aids & Evaluations | | 40% | 50% |
| Home Health Care | 130 visits per calendar year | 40% | 50% |
| Hospice Care | 14 days of respite care per lifetime | 40% | 50% |
| Hospital Care | | 40% | 50% |
| Mental Health/Substance Use Disorder - Inpatient | | 40% | 50% |
| Mental Health/Substance Use Disorder - Outpatient | | \$35 copay, deductible waived, 30% coinsurance for all other services | 50% coinsurance, deductible waived |
| Neurodevelopmental Therapy - Outpatient | 25 visits per calendar year Children under the age of 18 | \$35 copay, deductible waived | 50% |
| Nutritional Counseling | 3 visits per year | 40% | 50% |
| Palliative Care | 30 visits per calendar year | 40% | 50% |
| Rehabilitation Services - Inpatient | 30 days per calendar year | 40% | 50% |
| Rehabilitation Services - Outpatient | 30 visits per calendar year | \$35 copay, deductible waived | 50% |
| Retail Office Visits | Visits to a walk-in clinic located within a retail operation | \$20 copay per visit, deductible waived | 50% |
| Skilled Nursing Facility (SNF) Care | 60 days per calendar year | 40% | 50% |
| Spinal Manipulations - Osteopathic | | 40% | 50% |

| Medical Benefits (unless stated otherwise, a deductible applies) | | In-Network | Out-of-Network |
|--|--|-------------------------------|-------------------------|
| Virtual Care – Store & Forward Services | Asynchronous (not real-time) communications such as text or fax | \$20 copay, deductible waived | 50%, deductible applies |
| Virtual Care - Telehealth | Doctor visits via phone or video chat when <u>not</u> in a healthcare facility | \$20 copay, deductible waived | 50% |
| Vendor – Telehealth MDLive | Doctor visits via phone or video chat with an MDLive provider | No charge | Not covered |

| 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 prescription / \$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 specialty 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 20211

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 jii'k'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 ដោយមិនគិតល្អល គឺអាចមានសំរាប់បម្រើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਪਿਆਰ 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 እማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዙዎት 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 (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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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 بہ 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 فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)