



| Cost Share Details | | In-Network | Out-of-Network |
|------------------------------|----------------------------------------------------------------------------------|---------------------------------------|----------------------------------------|
| Annual Deductible | The total deductible you pay per calendar year | \$1,000 Individual \$2,000 Family | \$5,000 Individual \$10,000 Family |
| Annual Out-of-Pocket Maximum | The combined total for your deductible, coinsurance and copays per calendar year | \$8,550 Individual \$17,100 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 (unless stated otherwise, a deductible applies) | | 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 | | 20% | 50% |
| Preventive Care/Immunizations | | No charge | 50% |
| Radiology and Laboratory - Outpatient | | 20%, deductible waived | 50% |
| Complex Imaging - Outpatient | CT/PET/SPECT scans, MRIs, MRAs, etc. | 20% | 50% |
| Acupuncture and Chiropractic Spinal Manipulations | \$1,000 limit for all services combined | \$40 copay per visit, deductible waived | |
| Ambulance Services | | | 20% |
| Ambulatory Surgical Center | | 10% | 50% |
| Biofeedback | 10 visits per lifetime | 20% | 50% |
| Emergency Room (Including Professional Charges) | | | \$300 copay per visit |
| Employee Assistance Program (EAP) | 4 mental health counseling visits per issue | No charge | Not covered |
| Home Health Care | | 20% | 50% |
| Hospice Care | 5 consecutive days of respite care, with a maximum of 30 days per lifetime | 20% | 50% |
| Hospital Care - Inpatient | \$3,500 per day for inpatient non-emergency admissions to out-of-network facilities | 20% | 50% |
| Hospital Care - Outpatient | | 20% | 50% |
| Mental Health/Substance Use Disorder - Inpatient | \$3,500 per day for inpatient non-emergency admissions to out-of-network facilities | 20% | 50% |
| Mental Health/Substance Use Disorder - Outpatient | | \$40 copay per outpatient office/psychotherapy visit, deductible waived | 50% |
| Palliative Care | 30 visits per calendar year | 20% | 50% |

| Medical Benefits (unless stated otherwise, a deductible applies) | | What You Pay | |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------|
| | | In-Network | Out-of-Network |
| Rehabilitation Services - Inpatient | 30 days per 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 | 20% | 50% |
| Rehabilitation Services - Outpatient | 30 visits per calendar year | \$40 copay per visit, deductible waived | 50% |
| Reproductive Health Care Services | | Covered in full | 50% |
| Retail Office Visits | A visit 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 | 20% | 50% |
| Spinal Manipulations - Osteopathic | | 20% | 50% |
| Virtual Care - Store & 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 | \$10 copay per visit, deductible waived | 50% |
| Virtual Care - Telemedicine | Doctor visits via phone or video chat when in a healthcare facility | 20% | 50% |

| Pediatric Benefits - Dependents Under Age 19 (unless stated otherwise, a deductible applies) | | What You Pay | |
|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------|
| | | In-Network | Out-of-Network |
| Dental Care - Preventive | Cleanings, Oral Exams, Fluoride Treatment - 2 per calendar year X-rays - 1 set per calendar year Sealants - 1 per molar every 5 calendar years | 0%, deductible waived | |
| Dental Care - Basic | Fillings (limitations apply) Oral Surgery - includes removal of teeth and surgical extractions Emergency/Palliative Treatment - emergency pain relief Periodontal Maintenance - 2 per calendar year Scaling and root planing - 1 per 2 calendar years Endodontics - such as root canal | 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 | 50%, deductible waived | |
| Vision Care | Exams - 1 complete eye exam per calendar year Lenses - 1 pair of standard lenses per calendar year; includes scratch and UV protection Frames - 1 frame per calendar year Contacts - available once per year in lieu of all other lenses/frame benefits Find your vision plan benefits or a VSP vision provider at regence.com or call 1 (844) 299-3041 | \$0, deductible waived Frames - limited to Otis & Piper Eyewear collection | 50%, deductible waived |

| Prescription Medication Benefits (unless stated otherwise, a deductible applies) | | What You Pay |
|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------|
| Annual Deductible | The total deductible you pay per calendar year | Shared with medical |
| Annual Out-of-Pocket Maximum | The combined total for your deductible, coinsurance and copays per calendar year | Shared with medical |
| Preferred Generic | Deductible waived 90-day supply for retail or mail order | \$10 retail prescription* / \$20 mail order prescription |
| Generic | Deductible waived 90-day supply for retail or mail order | \$35 retail prescription* / \$70 mail order prescription |

| Prescription Medication Benefits (unless stated otherwise, a deductible applies) | | What You Pay |
|----------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------|
| Preferred Brand [^] | Deductible waived 90-day supply for retail or mail order | \$50 retail prescription* / \$100 mail order prescription |
| Brand | Deductible waived 90-day supply for retail or mail order | 50% retail prescription / 45% mail order prescription |
| Preferred Specialty | Deductible waived 30-day supply for retail | 20% participating pharmacy retail prescription |
| Specialty | Deductible waived 30-day supply for retail | 50% participating pharmacy retail prescription |

*1 copay per 30 day supply

[^]\$100 cap on member cost share per 30 day retail supply insulin

[^]\$200 cap on member cost share for up to 90 day supply of mail order insulin

20% for each self-administered Cancer Chemotherapy medication

More information about prescription drug coverage is available at <https://regence.com/go/2021/OR/6tier>

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. |

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。

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 ሊያግዝዎት 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, tajaajjila 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)