CIS Copay Plan F

Alternative Care and Hearing Aids

Benefits Summary
Effective January 1, 2022

cis benefits
www.cisbenefits.org

These medical plans are insured by CIS but administered by Regence BlueCross BlueShield (BCBS) of Oregon. This means that CIS, not Regence BCBS, pays for your covered medical services and supplies.

Copay Plan F	
Deductible Per Calendar Year	$500 Individual $1,500 Family
Out-of-Pocket Maximum Per Calendar Year **Category 1 & 2** - Preferred and Participating Provider (includes deductible and medical copays but does not include prescription copays)	$2,500 individual $5,500 family
Category 3 - Non-Preferred Provider (includes deductible and medical copays but does not include prescription copays)	$4,500 individual $9,500 family

Medical Services	**Member Pays** **Category 1 - Preferred**	**Member Pays** **Category 2 - Participating** **Category 3 - Non-Preferred**
Preventive Care Services		
Routine well-baby care, physical examinations, health screenings, and immunizations *(for a list of covered services, visit our website regence.com, hover over "Member dashboard" at the top, select Preventive Care from the drop down)*	0% for Category 1 & 2 (*deductible waived*) 40% for Category 3 (*after deductible*)	
Professional Services	**After Deductible – Member Pays**	
Office visits for illness or injury, mental/behavioral health or substance use disorder *(primary care, specialist, naturopath or urgent/immediate care center)*	$20 copay *(deductible waived)*	40%
Outpatient laboratory, radiology, and diagnostic procedures	$0 up to first $400 *(deductible waived)* then 20%	40%
Maternity care	20%	40%
Therapeutic injections including allergy shots	20%	40%
Hospital/Facility Services	**After Deductible - Member Pays**	
Ambulatory Surgical Center	10% *(20% for all other facilities)*	40%
Emergency room care *(including professional charges)*	20% after $100 copay *(copay waived if admitted)*	
Inpatient/outpatient surgery and surgeon fees	20%	40%
Inpatient mental/behavioral health & substance use disorder	20%	20% - Category 2 40%- Category 3
Skilled Nursing Facility – *120 inpatient days per year*	20%	40%
Other Services	**After Deductible - Member Pays**	
Ambulance	20%	
Rehabilitation Services*: Inpatient: Unlimited / Outpatient: 77 visits per year (visit limit shared with Neurodevelopmental therapy)*	20%	40%
Hearing Aids- *applies to children 18 years or younger or children 19 to 25 enrolled in an accredited education institution*	20%	40%
Home health care - *180 visits per year*	20%	40%
Hospice – *14 respite days/lifetime*	0% (deductible waived)	40%
Durable Medical Equipment	20%	40%
Weight Management/Nutritional Counseling and Bariatric Surgery: - Weight management and nutritional counseling visits *Four visits per plan year per member*	0% (deductible waived)	40%
- Bariatric surgery may be covered to treat morbid obesity (participant must meet participation requirements) *Limited to one surgery per claimant lifetime*	$1,000 copay then 20% *(does not accumulate towards the out-of-pocket maximum)*	$1,000 copay then 40% *(does not accumulate towards the out-of-pocket maximum)*

Prescription Medication Benefit *If you need drugs to treat your illness or condition, your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182.* *Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.*	**At the Pharmacy (30-day supply) Member Pays**	**Mail Order thru the Express Scripts Pharmacy Program (90-day supply) Member Pays**
Individual deductible per calendar year	No deductible	
Out-of-pocket maximum each calendar year	$2,500 per person/$7,500 per family	
Generic drugs	$10 copay	$20 copay
Preferred brand drugs	$40 copay	$80 copay
Non-Preferred brand drugs	$100 copay	$200 copay
	Accredo Specialty Pharmacy (30-day supply)	
Specialty Generic	$50 copay	N/A
Specialty Preferred brand drugs	$100 copay	N/A
Specialty Non-Preferred brand drugs	$200 copay	N/A
Limitations and Exceptions	***Out-of-pocket limit*** $2,500 */ claimant / year. Coverage is limited to 30-day supply retail or 90-day supply mail order. Long-term medication fills at participating retail pharmacies may be filled for up to a 90-day supply and will follow the mail order copayment structure. Visit Express Scripts' website for details. Specialty drug coverage is limited to a 30-day supply and must be filled through Accredo Specialty Pharmacy.* *Specialty medications filled at a retail pharmacy are subject to 100% copayment/coinsurance, and this amount does not accumulate towards the out-of-pocket maximum.* *Certain preventive items and services as defined by the Affordable Care Act are covered at zero-dollar cost share. Product Selection Cost – If you request and obtain a brand name drug when a generic equivalent is available, you are responsible for the applicable copayment plus the cost difference between the brand name drug and the generic drug.*	

Additional Medical Services

Alternative Care Services	
Acupuncture and Chiropractic Spinal Manipulations	No deductible, any provider - $20 Copay – Maximum allowance of 12 visits per calendar year for Acupuncture and 20 visits per calendar year for Chiropractic Spinal Manipulations.

Hearing Aids and Hearing Exam – Member Pays	
Hearing Aids	Paid at 100% up to a maximum of $3,000 every 4 calendar years. The $3,000 is an accumulative amount over the 4 calendar years and not a one-time benefit.
Hearing Examination	One exam every calendar year. Covered at 20% using a Category 1 provider, 40% using a Category 2 or 3 provider; not subject to the deductible. Does not accumulate toward the out-of-pocket maximum.

Other services included in your CIS medical plan	**Contact Information**
MDLIVE (Telehealth) - With MDLIVE's telehealth service, you can see a doctor or therapist from home, work or on the go, 24/7/365. Board-certified doctors visit with you by phone or secure video to treat non-emergency medical conditions. They can diagnose symptoms, prescribe medication, and send prescriptions to your pharmacy.	To learn more call 1 (888) 725-3097 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Telehealth.
Chronic Condition Coaching supports and educates members with chronic conditions including hypertension, diabetes, COPD, CAD, CHF, asthma and obesity.	To learn more, please call 1 (866) 865-6725.
BeyondWell - A comprehensive well-being solution for members that integrates wellness activities, goals, rewards and challenges into a single location for a holistic wellness offering.	To learn more, please call 1 (866) 865-6725 or sign on to the CIS Health Manager at www.regence.com and click on BeyondWell.
Case Management - Supports and educates members with serious illnesses or injuries.	To learn more, please call 1 (866) 543-5765 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Case Management.
BabyWise (*Childbirth to Newborn resources*).	To learn more, call 1 (888) 569-2229 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Maternity.
BlueCard Program (Out of Area Services) – access hospital and physicians when outside the four-state area Regence services (Oregon, Idaho, Utah and Washington) as well as receive care in 200 countries around the world.	Find a provider near you at www.regence.com or call 1 (800) 810-BLUE (2583).

A LOOK AT YOUR CIS TRUST VISION PLAN - A COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM CIS TRUST - VISION PLAN-A

cis benefits
cisbenefits.org

As a member of CIS' vision plan, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premier Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

PREMIER PROGRAM

Visionworks

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON
LACOSTE NINE WEST

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

+ UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

VSP® Vision Care

Contact us: **800.877.7195** or **vsp.com**

This vision plan is insured by CIS but administered by VSP. This means that CIS, not VSP, pays for your covered vision services and supplies.

YOUR VISION BENEFITS SUMMARY

CIS TRUST VISION PLAN-A

EFFECTIVE DATE: 01/01/2022

PROVIDER NETWORK:
VSP Choice

cis benefits
cisbenefits.org

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
PRESCRIPTION GLASSES		$25	See frame and lenses
FRAME	• $170 frame allowance • $190 featured frame brands allowance • 20% savings on the amount over your allowance • $95 Costco®/Walmart/Sam's Club® frame allowance	Included in Prescription Glasses Copay	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses copay	Every calendar year
LENS ENHANCEMENTS	∇ All progressive lenses • Photochromic lenses/tints • Polycarbonate lenses • Scratch coating • Anti-reflective/Blue Light coating • UV Protection • Average savings of 30% on other lens enhancements	$50 $0 $0 $0 $0 $0	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $166 allowance for contacts and contact lens fitting and evaluation exam; copay does not apply	$0	Every calendar year
SAFETY® (EMPLOYEE-ONLY COVERAGE)			
FRAME	• $65 allowance for a safety frame; 20% savings on amount over your allowance • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0 for frame and lenses	Every other calendar year
LENSES	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	Included in Frame Allowance	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Exam ..... up to $50	Lenticular Lenses..... up to $105	Contacts ..... up to $110
Single Vision Lenses ..... up to $35	Progressive Lenses ..... up to $105	Frame ..... up to $70
Lined Bifocal Lenses ..... up to $55	Tints ..... up to $5	Necessary Contact Lenses..... up to $215
Lined Trifocal Lenses ..... up to $70		

Submit claims for out-of-network providers on-line at vsp.com or send a claim form along with your itemized receipt to:
VSP OA Claims; PO Box 385018, Birmingham, AL 35238-5018

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Log in to **vsp.com** to find an in-network provider based on your plan type.

This vision plan is insured by CIS but administered by VSP. This means that CIS, not VSP, pays for your covered vision services and supplies.

*Only available to employees. Lens enhancements are not covered for safety glasses. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

Welcome to Express Scripts

CIS and Express Scripts want you to know that Express Scripts manages your prescription plan. We care about your health and work to make medications safer and more affordable. We encourage you to take advantage of the services and resources available to help you and your dependents manage your pharmacy benefit. We look forward to serving you soon!

Why pay more? Make the move to a 3-month supply.

Under your prescription plan, you have the option to order 3-month supplies of long-term medications from certain participating retail pharmacies or through home delivery from Express Scripts® Pharmacy. [1]

To start ordering a 3-month supply from Express Scripts® Pharmacy, register or log in at **express-scripts.com**. (Standard shipping is free with home delivery.[2])

To find a retail pharmacy that participates in 3-month supplies, log in at **express-scripts.com** and choose Find a Pharmacy from the menu under Prescriptions. The pharmacy can tell you how to transfer your prescription or start a new one. Search results will indicate whether a pharmacy is eligible to dispense up to a 3-month supply.

According to your plan, you can keep filling one month at a time but you could miss out on convenience and savings.

[1]Long-term medications are taken for an ongoing condition, such as high blood pressure, high cholesterol and asthma.
[2]Cost of standard shipping is included as part of your prescription plan.

Accredo, Your Specialty Pharmacy

Accredo is the Express Scripts specialty pharmacy. A specialty pharmacy provides medication and therapy for patients with serious, chronic conditions like cancer and hepatitis C. Accredo offers teams of pharmacists, nurses and clinicians who are specially trained on your condition. This level of individualized, focused care gives you the most comprehensive, compassionate and customized care available.

Accredo offers many patient support services, including:

- Personal care and health advocacy assistance from patient care coordinators
- Coordination of financial assistance (availability varies by plan)
- Guidance for patients and caregivers for taking specialty medications most effectively
- All necessary ancillary supplies such as syringes and sharps containers

Specialty medications must be filled through Accredo to receive coverage. To learn more about Accredo, please visit **accredo.com.**

CIS has partnered with SaveonSP to provide a specialty pharmacy copayment assistance program. If you attempt to fill a specialty prescription that falls under this program, an Accredo representative will assist you with enrollment in the program by transferring you to SaveonSP. More information about this program can be found in your Plan Booklet.

EXPRESS SCRIPTS®

Network Retail Pharmacies

Network pharmacies are retail pharmacies that are preferred by your prescription plan. Use them for prescriptions you need on a short-term basis, like an antibiotic to treat an infection. When you go to an in-network pharmacy for up to a 30-day supply of medication, you'll typically pay less than at a retail pharmacy that's out of your network.

To find an in-network pharmacy near you, go to **express-scripts.com/CIS6** and select Locate a Pharmacy. Search results will indicate whether a pharmacy is eligible to dispense up to a 3-month supply. You may also log in at **express-scripts.com** and choose **Find a Pharmacy** from the menu under **Prescriptions** or call Express Scripts at 800.496.4182.

If you're new to Regence BCBS coverage, be sure to show your new Express Scripts ID card at the pharmacy. You can also access your ID card by downloading the Express Scripts® mobile app. If you don't show your ID card and instead choose to pay the entire cost of the medication, you must submit a claim form to Express Scripts for reimbursement. You'll be reimbursed based on the covered medication's contracted rate minus the appropriate copayment. This amount will be lower than the amount you paid out of pocket at the retail pharmacy.

If you need to transfer your prescription from an out-of-network pharmacy to an in-network pharmacy, just choose one of the following:

- Bring your prescription vial or container to an in-network pharmacy, and the pharmacist will transfer it.
- Call a pharmacy in your network, and ask the pharmacist to transfer your medication.
- Ask your doctor to send your prescription in to an in-network pharmacy using e-prescribing.

Manage Your Prescription

One of the great things about being an Express Scripts member is that you can manage your medication easily on your laptop, tablet, desktop or phone. Whether you want to check your order status, look for savings opportunities, look up information about your benefit, get a refill or even find a pharmacy, the Express Scripts website and mobile app can help!

Just register at express-scripts.com or download the mobile app to your mobile device for free by searching your app store for Express Scripts. (Availability and features may vary.)

Formulary

A preferred medication list, also called a formulary, helps keep healthcare costs down for everybody. It's a list of medications that have been reviewed and approved for safety and effectiveness by a panel of doctors and pharmacists. This list is continually reviewed and updated as new medications become available.

Note that certain medications are excluded from your formulary, which means they're not covered. An equally effective and safe alternative may be available. To check pricing and coverage for a medication, visit express-scripts.com/CIS6. Drug classes with excluded medications include Autonomic and Central Nervous System, Cardiovascular and Dermatological.

EXPRESS SCRIPTS®

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1 (888) 370-6159. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 370-6159 to request a copy. **Please Note:** Your medical plan is provided and insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 individual / $1,500 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Preferred & Participating: $2,500 individual / $5,500 family per calendar year. Nonparticipating: $4,500 individual / $9,500 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, prescription drug out-of-pocket limit balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/OR/Preferred or call 1 (888) 370-6159 for a list of network providers.	You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a nonparticipating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a nonparticipating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	40% coinsurance	Copayment applies to each preferred office and retail clinic visit only. All other services are covered at the coinsurance specified, after deductible. Alternative Care services (acupuncture and chiropractic spinal manipulations) are subject to $20 copayment / visit, deductible does not apply. 12 acupuncture visits / year 20 chiropractic spinal manipulation visits / year
	Specialist visit	$20 copay / office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	Coinsurance and deductible waived for childhood immunizations from nonparticipating providers. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for the first $400 / year, then 20% coinsurance	40% coinsurance	40% coinsurance	$400 combined for outpatient diagnostic tests and imaging / year for preferred providers
	Imaging (CT/PET scans, MRIs)	No charge for the first $400 / year, then 20% coinsurance	40% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition	Specialty generic drugs & generic drugs	$50 copay / specialty retail prescription $10 copay / retail prescription $20 copay / mail order prescription			Out-of-pocket limit: $2,500 claimant / $7,500 family / year. 30-day supply / retail prescription 90-day supply / mail order prescription

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
Your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.	Preferred brand drugs	$40 copay / retail prescription $80 copay / mail order prescription			Long term medication fills at participating retail pharmacies may be filled for up to a 90-day supply and will follow the mail order copayment structure. Visit Express Scripts website for details. 30-day supply / specialty drug prescription Specialty drug coverage is limited to a 30-day supply and must be filled through Accredo Specialty Pharmacy. Specialty medications filled at a retail pharmacy are subject to 100% copayment / coinsurance, and this amount does not accumulate towards the out-of-pocket limit. Certain preventive items and services as defined by the Affordable Care Act are covered at zero dollar cost share. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. Production Selection Cost – If you request and obtain a brand name drug when a generic equivalent is available, you are responsible for the applicable copayment and/or coinsurance plus the cost difference between the brand name drug and the generic drug.
	Brand drugs	$100 copay / retail prescription $200 copay / mail order prescription			
	Preferred specialty drugs & specialty drugs	$100 copay / preferred specialty prescription $200 copay / preferred specialty prescription			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities	40% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance for ambulatory surgery center physicians;	40% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
		20% coinsurance for all other physicians			
If you need immediate medical attention	Emergency room care	20% coinsurance after $100 copay / visit	20% coinsurance after $100 copay / visit	20% coinsurance after $100 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	Preferred and participating deductible applies to preferred, participating and nonparticipating services.
	Urgent care	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** above.			None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / office visit, deductible does not apply; No charge for all other services	$20 copay / office visit, deductible does not apply; No charge for all other services	40% coinsurance	Copayment applies to each preferred or participating office/psychotherapy visit only. All other services are covered at the coinsurance specified, after deductible.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	40% coinsurance	180 visits / year
	Rehabilitation services	20% coinsurance	40% coinsurance	40% coinsurance	77 outpatient visits / year for all habilitation and outpatient rehabilitation services
	Habilitation services	20% coinsurance	40% coinsurance	40% coinsurance	Includes physical therapy, occupational therapy,

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
					speech therapy and neurodevelopmental therapy services. Neurodevelopmental therapy limited to individuals under age 18.
	Skilled nursing care	20% coinsurance	40% coinsurance	40% coinsurance	120 inpatient days / year
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	None
	Hospice services	No charge	No charge	40% coinsurance	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care, spinal manipulations only
- Hearing aids (Adult)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 370-6159. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (888) 370-6159 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also

contact the Oregon Division of Financial Regulation by calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFRInsuranceHelp@oregon.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1 (888) 370-6159.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$500**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,561**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$500**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$254
Coinsurance	$683
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$1,615**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$500**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$165
Coinsurance	$348
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,013**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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'dęę', t'áá jiik'eh, éí ná hóló, kojį' 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 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)