



Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per calendar year	\$250 Individual \$750 Family	\$750 Individual \$2,250 Family
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	\$1,250 Individual \$3,750 Family	\$3,500 Individual \$10,500 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)		\$20 copay per visit, deductible waived	30%
Specialist Visits		\$30 copay per visit, deductible waived	30%
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		10%	30%
Preventive Care/Immunizations		No charge	30%
Radiology and Laboratory - Outpatient		10%	30%
Complex Imaging - Outpatient	CT/PET/SPECT scans, MRIs, MRAs, etc.	10%	30%
Acupuncture	25 visits per calendar year	\$20 copay per visit, deductible waived	30%
Ambulance Services			10%
Ambulatory Surgical Center		5%	30%
Emergency Room (Including Professional Charges)		\$200 copay per visit, then 10% coinsurance	
Hearing Aids & Evaluations		10%	30%
Home Health Care	130 visits per calendar year	10%	30%
Hospice Care	14 days of respite care per lifetime	10%	30%
Hospital Care		10%	30%
Mental Health/Substance Use Disorder - Inpatient		10%	30%
Mental Health/Substance Use Disorder - Outpatient		\$20 copay per outpatient office/psychotherapy visit, deductible waived	30%
Newborn Home Visits	Within 6 months of age, at least one visit during first 3 months, with up to 3 more available	0%, deductible waived	Not covered
Neurodevelopmental Therapy - Outpatient	20 visits per calendar year Children under the age of 18	\$20 copay per visit, deductible waived	30%
Nutritional Counseling	3 visits per calendar year	10%	30%
Palliative Care	30 visits per calendar year	10%	30%
Rehabilitation Services - Inpatient	30 days per calendar year	10%	30%
Rehabilitation Services - Outpatient	20 visits per calendar year	\$20 copay per visit, deductible waived	30%
Retail Office Visits	Visits to a walk-in clinic located within a retail operation	\$20 copay per visit, deductible waived	30%

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
		In-Network	Out-of-Network
Skilled Nursing Facility (SNF) Care	100 days per calendar year	10%	30%
Spinal Manipulations - Osteopathic	25 visits per calendar year	\$20 copay per visit, deductible waived	30%
Virtual Care - Telehealth	Doctor visits via phone or video chat when <u>not</u> in a healthcare facility	Vendor: Doc on Demand \$10 copay per visit, deductible waived	Not Covered
		In-Network non-Vendor Provider: \$20 copay per visit, deductible waived	30%
Virtual Care - Telemedicine	Doctor visits via phone or video chat when in a healthcare facility	10%	30%

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 / \${0 / 250 / 500}]
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with medical
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 retail prescription* / \$60 mail order prescription / \$50 for each self-administrable Cancer Chemotherapy medication
Brand	90-day supply for retail or mail order	\$45 retail prescription* / \$45 mail order prescription / \$100 for each self-administrable Cancer Chemotherapy medication
Specialty	30-day supply for retail	Refer to Generic, Preferred Brand and Brand above for participating pharmacy retail prescription

*1 copay per 30 day supply

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

[^]\$300 cap on member cost share for up to 90 day supply of mail order insulin, deductible waived

More information about prescription drug coverage is available at <https://regence.com/go/2021/OR/3tier>

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。

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jii'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)។

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፣ በገጸ ሊያገለግሉት 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)

ប្រគល់: បើសិនជា អ្នកនិយាយ ភាសា ខ្មែរ, ការបំរើការជំនួយផ្នែកភាសា, ដោយមិនគិតល្អល គឺអាចមានសំរាប់បម្រើអ្នក។ ចូរ ទូរស័ព្ទ 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 فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)

Regence HSA Healthplan 3.0SM

Effective January 1, 2022 through December 31, 2022



Regence

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

Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per calendar year	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	\$3,000 Individual \$6,000 Family	\$9,000 Individual \$18,000 Family

The In-Network Out-of-Pocket Maximum for any Member on Family Coverage is not to exceed \$6,000, including the In-Network Deductible. If a Member reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, including the In-Network Deductible, benefits will be paid at 100% of the Allowed Amount for that Member.

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)		20%	40%
Specialist Visits		20%	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%
Preventive Care/Immunizations		No charge	40%
Radiology and Laboratory - Outpatient		20%	40%
Complex Imaging - Outpatient	CT/PET/SPECT scans, MRIs, MRAs, etc.	20%	40%
Acupuncture	25 visits per calendar year	20%	40%
Ambulance Services			20%
Ambulatory Surgical Center		10%	40%
Emergency Room (Including Professional Charges)			20%
Hearing Aids & Evaluations		20%	40%
Home Health Care	130 visits per calendar year	20%	40%
Hospice Care	14 days of respite care per lifetime	20%	40%
Hospital Care		20%	40%
Mental Health/Substance Use Disorder - Inpatient		20%	40%
Mental Health/Substance Use Disorder - Outpatient		20%	40%
Newborn Home Visits	Within 6 months of age, at least one visit during first 3 months, with up to 3 more available	0%	Not covered
Neurodevelopmental Therapy - Outpatient	20 visits per calendar year Children under the age of 18	20%	40%
Nutritional Counseling	3 visits per calendar year	20%	40%
Palliative Care	30 visits per calendar year	20%	40%
Rehabilitation Services - Inpatient	30 days per calendar year	20%	40%
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Retail Office Visits	Visits to a walk-in clinic located within a retail operation	20%	40%
Skilled Nursing Facility (SNF) Care	100 days per calendar year	20%	40%

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
		In-Network	Out-of-Network
Spinal Manipulations - Osteopathic		20%	40%
Virtual Care - Telehealth	Doctor visits via phone or video chat when <u>not</u> in a healthcare facility	Vendor: Doc on Demand 10%	Not Covered
		In-Network non-Vendor Provider: 20%	40%
Virtual Care - Telemedicine	Doctor visits via phone or video chat when in a healthcare facility	20%	40%

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
Generic [†]	90-day supply for retail or mail order	\$15 retail prescription / \$30 mail order prescription
Preferred Brand ^{† ^}	90-day supply for retail or mail order	\$30 retail prescription / \$60 mail order prescription
Brand	90-day supply for retail or mail order	\$45 retail prescription / \$90 mail order prescription
Specialty	30-day supply for retail	Refer to Generic, Preferred Brand and Brand above for participating pharmacy retail prescription

[†]Deductible waived on retail prescriptions for medications on the Optimum Value Medication List (OVML) located on our website

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

[^]\$300 cap on member cost share for up to 90 day supply of mail order insulin, deductible waived
20% for each self-administered Cancer Chemotherapy medication

More information about prescription drug coverage is available at <https://regence.com/go/2021/OR/3tier>

Frequently Asked Questions

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Customer Service for all other plans

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Civil Rights Coordinator

MS: B32AG, PO Box 1827

Medford, OR 97501

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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

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D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jii'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 ដោយមិនគិតល្អល្អ គឺអាចមានសំរាប់បម្រើអ្នក។ 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)

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ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

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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 فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)