

# PIONEER EDUCATORS HEALTH TRUST Medical Plan

Coverage Period: 04/01/2015 – 03/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Eligible Family | Plan Type: PPO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.Regence.com](http://www.Regence.com) or by calling 1 (866) 240-9580.

| Important Questions                                       | Answers                                                                                                                                                                                                                                                                                                                                                                                                                                 | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                   | <b>Preferred</b> & Participating: <b>\$500</b> claimant / <b>\$1,500</b> family per calendar year.<br>Non-Participating: <b>\$1,000</b> claimant / <b>\$3,000</b> family per calendar year.<br>Doesn't apply to certain preventive care, <b>emergency room care</b> or outpatient mental health and substance abuse.<br><b>Copayments</b> or amounts in excess of the <b>allowed amount</b> do not count toward the <b>deductible</b> . | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .                                                                                             |
| Are there other <u>deductibles</u> for specific services? | No.                                                                                                                                                                                                                                                                                                                                                                                                                                     | You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                                                                                                                                                                                                                                                              |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | Yes. <b>Preferred</b> & Participating: <b>\$3,500</b> claimant / <b>\$10,500</b> family per calendar year.<br>Non-Participating: <b>\$10,500</b> claimant / <b>\$31,500</b> family per calendar year.                                                                                                                                                                                                                                   | The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.                                                                                                                                                                                                                                                          |
| What is not included in the <u>out-of-pocket limit</u> ?  | <b>Premiums</b> , balance-billed charges, and health care this plan doesn't cover.                                                                                                                                                                                                                                                                                                                                                      | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .                                                                                                                                                                                                                                                                                                                                                                      |
| Does this plan use a <u>network of providers</u> ?        | Yes. See <a href="http://www.Regence.com">www.Regence.com</a> or call 1 (866) 240-9580 for lists of <b>preferred</b> or participating <b>providers</b> .                                                                                                                                                                                                                                                                                | If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <u>specialist</u> ?         | No. You don't need a referral to see a <b>specialist</b> .                                                                                                                                                                                                                                                                                                                                                                              | You can see the <b>specialist</b> you choose without permission from this plan.                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services this plan doesn't cover?               | Yes.                                                                                                                                                                                                                                                                                                                                                                                                                                    | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .                                                                                                                                                                                                                                                                                                   |

**Questions:** Call 1 (866) 240-9580 or visit us at [www.Regence.com](http://www.Regence.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1 (866) 240-9580 to request a copy.

Claims Administrator: Regence BlueCross BlueShield of Oregon

OO0115SPRFX



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred** and participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event                                          | Services You May Need                            | Your Cost If You Use a Preferred Provider          | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------|-----------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care <b>provider's</b> office or clinic | Primary care visit to treat an injury or illness | \$25 copay / visit, other services 20% coinsurance | 40% coinsurance                               | 40% coinsurance                                   | <b>Copayment</b> applies to each <b>preferred</b> office visit only, <b>deductible</b> waived. All other services are covered at the <b>coinsurance</b> specified, after <b>deductible</b> . Includes surgeries performed in the office, allergy shots and therapeutic injections. All other services are covered at the <b>coinsurance</b> specified, after <b>deductible</b> . |
|                                                               | Specialist visit                                 | \$25 copay / visit, other services 20% coinsurance | 40% coinsurance                               | 40% coinsurance                                   |                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                               | Other practitioner office visit                  | 20% coinsurance                                    | 40% coinsurance                               | 40% coinsurance                                   |                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                               | Preventive care/ screening/immunization          | No charge                                          | No charge                                     | 40% coinsurance                                   |                                                                                                                                                                                                                                                                                                                                                                                  |
| If you have a test                                            | Diagnostic test (x-ray, blood work)              | 20% coinsurance                                    | 40% coinsurance                               | 40% coinsurance                                   | <b>Deductible</b> waived for outpatient diagnostic tests and imaging for <b>preferred providers</b> .                                                                                                                                                                                                                                                                            |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 20% coinsurance                                    | 40% coinsurance                               | 40% coinsurance                                   |                                                                                                                                                                                                                                                                                                                                                                                  |

| Common Medical Event                                                                                                                                                                                      | Services You May Need                          | Your Cost If You Use a Preferred Provider                                                                                                        | Your Cost If You Use a Participating Provider      | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions                                                                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.Regence.com">www.Regence.com</a> . | Generic drugs                                  | \$20 copay / retail prescription<br>\$30 copay / mail order prescription                                                                         |                                                    |                                                   | Coverage is limited to a 30-day supply retail, 90-day supply mail order or 30-day supply injectable and specialty drugs. Brand-name medications for tobacco use cessation are limited to \$500 / lifetime.                                      |
|                                                                                                                                                                                                           | Preferred brand drugs                          | \$40 copay / retail prescription<br>\$60 copay / mail order prescription                                                                         |                                                    |                                                   |                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                           | Non-preferred brand drugs                      | \$60 copay / retail prescription<br>\$90 copay / mail order prescription                                                                         |                                                    |                                                   |                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                           | Specialty drugs                                | Refer to generic, preferred brand and non-preferred brand drugs above.                                                                           |                                                    |                                                   |                                                                                                                                                                                                                                                 |
| <b>If you have outpatient surgery</b>                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance                                                                                                                                  | 40% coinsurance                                    | 40% coinsurance                                   | _____none_____                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                           | Physician/surgeon fees                         | 20% coinsurance                                                                                                                                  | 40% coinsurance                                    | 40% coinsurance                                   | _____none_____                                                                                                                                                                                                                                  |
| <b>If you need immediate medical attention</b>                                                                                                                                                            | Emergency room services                        | 20% coinsurance after \$250 copay / visit                                                                                                        | 20% coinsurance after \$250 copay / visit          | 20% coinsurance after \$250 copay / visit         | <b><u>Copayment</u></b> applies to the facility charge for each visit (waived if admitted). <b><u>Deductible</u></b> waived.                                                                                                                    |
|                                                                                                                                                                                                           | Emergency medical transportation               | 20% coinsurance                                                                                                                                  | 20% coinsurance                                    | 20% coinsurance                                   | _____none_____                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                           | Urgent care                                    | Covered the same as the <b>If you visit a health care <u>provider's</u> office or clinic</b> or <b>If you have a test</b> Common Medical Events. |                                                    |                                                   | _____none_____                                                                                                                                                                                                                                  |
| <b>If you have a hospital stay</b>                                                                                                                                                                        | Facility fee (e.g., hospital room)             | 20% coinsurance                                                                                                                                  | 40% coinsurance                                    | 40% coinsurance                                   | _____none_____                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                           | Physician/surgeon fee                          | 20% coinsurance                                                                                                                                  | 40% coinsurance                                    | 40% coinsurance                                   | _____none_____                                                                                                                                                                                                                                  |
| <b>If you have mental health, behavioral health, or substance abuse needs</b>                                                                                                                             | Mental/Behavioral health outpatient services   | \$25 copay / visit, other services 20% coinsurance                                                                                               | \$25 copay / visit, other services 20% coinsurance | 40% coinsurance                                   | <b><u>Deductible</u></b> waived for outpatient services. <b><u>Copayment</u></b> applies to each <b><u>preferred</u></b> and participating outpatient therapy visit. All other services are covered at the <b><u>coinsurance</u></b> specified. |
|                                                                                                                                                                                                           | Mental/Behavioral health inpatient services    | 20% coinsurance                                                                                                                                  | 20% coinsurance                                    | 40% coinsurance                                   |                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                           | Substance use disorder outpatient services     | \$25 copay / visit, other services 20% coinsurance                                                                                               | \$25 copay / visit, other services 20% coinsurance | 40% coinsurance                                   |                                                                                                                                                                                                                                                 |

| Common Medical Event                                           | Services You May Need                     | Your Cost If You Use a Preferred Provider | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions                                                                                                                                                           |
|----------------------------------------------------------------|-------------------------------------------|-------------------------------------------|-----------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                | Substance use disorder inpatient services | 20% coinsurance                           | 20% coinsurance                               | 40% coinsurance                                   |                                                                                                                                                                                    |
| If you are pregnant                                            | Prenatal and postnatal care               | 20% coinsurance                           | 40% coinsurance                               | 40% coinsurance                                   | _____none_____                                                                                                                                                                     |
|                                                                | Delivery and all inpatient 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                                   | Coverage is limited to 180 visits / year.                                                                                                                                          |
|                                                                | Rehabilitation services                   | 20% coinsurance                           | 40% coinsurance                               | 40% coinsurance                                   | Coverage is limited to 30 inpatient days / year.<br>Coverage is limited to 25 outpatient visits / year.                                                                            |
|                                                                | Habilitation services                     | 20% coinsurance                           | 40% coinsurance                               | 40% coinsurance                                   | Coverage for neurodevelopmental therapy is limited to 25 outpatient visits / year.<br>Coverage for neurodevelopmental therapy is limited to services for claimants through age 17. |
|                                                                | Skilled nursing care                      | 20% coinsurance                           | 40% coinsurance                               | 40% coinsurance                                   | Coverage is limited to 100 inpatient days / year.                                                                                                                                  |
|                                                                | Durable medical equipment                 | 20% coinsurance                           | 40% coinsurance                               | 40% coinsurance                                   | Coverage for wigs is limited to 1 wig / year.                                                                                                                                      |
|                                                                | Hospice service                           | 20% coinsurance                           | 40% coinsurance                               | 40% coinsurance                                   | Coverage is limited to 180 respite days / lifetime.                                                                                                                                |
| If your child needs dental or eye care                         | Eye exam                                  | Not covered                               | Not covered                                   | Not covered                                       | Coverage is limited to 1 routine exam / year for claimants under age 19, <b>deductible</b> waived.                                                                                 |
|                                                                | Glasses                                   | Not covered                               | Not covered                                   | Not covered                                       | Coverage is limited to 1 pair of lenses and 1 frame / year for claimants under age 19, <b>deductible</b> waived.                                                                   |
|                                                                | Dental check-up                           | Not covered                               | Not covered                                   | Not covered                                       | _____none_____                                                                                                                                                                     |

## Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)                                                                                  |                                                                                                                                                                  |                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Chiropractic Care</li><li>• Cosmetic surgery, except congenital anomalies</li></ul>                                            | <ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Long-term care</li><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Routine foot care</li><li>• Vision hardware</li><li>• Weight loss programs except for nutritional counseling</li></ul> |
| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)                                                                    |                                                                                                                                                                  |                                                                                                                                                                |
| <ul style="list-style-type: none"><li>• Hearing aids for claimants 18 or younger or for enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment for diagnosis and treatment only</li></ul>                                                         | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul>                                                           |

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (866) 240-9580. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (866) 240-9580 or visit [www.Regence.com](http://www.Regence.com). You may also contact the Oregon Insurance Division by calling (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: [www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx](http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx); or by E-mail at: [cp.ins@state.or.us](mailto:cp.ins@state.or.us) or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (866) 240-9580.

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

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$5,520
- **Patient pays:** \$2,020

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$500          |
| Copays               | \$20           |
| Coinsurance          | \$1,350        |
| Limits or exclusions | \$150          |
| <b>Total</b>         | <b>\$2,020</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$3,600
- **Patient pays:** \$1,800

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$500          |
| Copays               | \$670          |
| Coinsurance          | \$590          |
| Limits or exclusions | \$40           |
| <b>Total</b>         | <b>\$1,800</b> |



## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.





**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.Regence.com](http://www.Regence.com) or by calling 1 (866) 240-9580.

| Important Questions                                       | Answers                                                                                                                                             | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                   | This plan has no <u>deductible</u> .                                                                                                                | See the chart starting on page 2 for your costs for services this plan covers.                                                                                                                                                                                                                                                                                                                                                     |
| Are there other <u>deductibles</u> for specific services? | No.                                                                                                                                                 | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                                                                                                                                                                                                                               |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | No.                                                                                                                                                 | There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.                                                                                                                                                                                                                                                                                                                |
| What is not included in the <u>out-of-pocket limit</u> ?  | This plan has no <u>out-of-pocket limit</u> .                                                                                                       | Not applicable because there's no <u>out-of-pocket limit</u> on your expenses.                                                                                                                                                                                                                                                                                                                                                     |
| Does this plan use a <u>network of providers</u> ?        | Yes. See <a href="http://www.Regence.com">www.Regence.com</a> or call 1 (866) 240-9580 for lists of in-network or out-of-network <u>providers</u> . | If you use an in-network <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network <u>provider</u> may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ?         | No. You don't need a referral to see a <u>specialist</u> .                                                                                          | You can see the <u>specialist</u> you choose without permission from this plan.                                                                                                                                                                                                                                                                                                                                                    |
| Are there services this plan doesn't cover?               | Yes.                                                                                                                                                | Some of the services this plan doesn't cover are listed on page 3. See your policy or plan document for additional information about <u>excluded services</u> .                                                                                                                                                                                                                                                                    |

**Questions:** Call 1 (866) 240-9580 or visit us at [www.Regence.com](http://www.Regence.com).

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered vision care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a vision examination is \$50, your **coinsurance** payment of 20% would be \$10. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network **provider** charges \$150 for a vision examination and the **allowed amount** is \$50, you may have to pay the \$100 difference. (This is called **balance billing**.)

| Common Medical Event                                        | Services You May Need      | Your Cost If You Use a Preferred Provider | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-participating Provider | Limitations & Exceptions                                                                 |
|-------------------------------------------------------------|----------------------------|-------------------------------------------|-----------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------|
| If you visit an eye care <b>provider's</b> office or clinic | Routine vision examination | No Charge                                 | No Charge                                     | No Charge                                         | Coverage is limited to 1 routine eye exam / year.                                        |
|                                                             | Vision hardware            | No charge up to \$250 hardware maximum    | No charge up to \$250 hardware maximum        | No charge up to \$250 hardware maximum            | Coverage is limited to \$250 for covered vision hardware / year and you pay any balance. |

Excluded Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .) |                           |                              |
|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------|------------------------------|
| • Contact fittings                                                                                                                      | • Medical services        | • Prescription medication    |
| • Cosmetic services and supplies                                                                                                        | • Non-direct patient care | • Vision therapy and surgery |
| • Fees, taxes, interest                                                                                                                 | • Personal comfort items  |                              |