



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 [regence.com](http://regence.com) or call 1 (866) 240-9580. 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](http://healthcare.gov/sbc-glossary) or call 1 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Preferred</u> & Participating: \$1,500 individual / \$4,500 family per calendar year. Nonparticipating: \$3,000 individual / \$9,000 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>preventive care</u> and the following services: <u>preferred office/urgent care</u> visits, <u>preferred outpatient diagnostic test/imaging</u> services, <u>emergency room care</u> and outpatient mental health and substance use disorder services.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>Preferred</u> & Participating: \$4,000 individual / \$12,000 family per calendar year. Nonparticipating: \$8,000 individual / \$24,000 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://regence.com/go/Preferred">regence.com/go/Preferred</a> or call 1 (866) 240-9580 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay the least if you use a <u>provider</u> in the preferred <u>network</u> . You pay more if you use a <u>provider</u> in the participating <u>network</u> . You will pay the most if you use a nonparticipating <u>provider</u> , and you might receive a bill from a nonparticipating <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use a nonparticipating <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$12 <u>copay</u> / visit for BDTC* <u>providers</u> , <u>deductible</u> does not apply; \$25 <u>copay</u> / visit for all other <u>providers</u> , <u>deductible</u> does not apply; other services 20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	<p><u>Copayment</u> applies to each <u>preferred</u> office visit only. Includes surgeries performed in the office, allergy shots and therapeutic injections. All other services that are not billed as an office visit are covered at the coinsurance specified, after <u>deductible</u>.</p> <p>Coverage for alternative care (acupuncture and chiropractic spinal manipulations) is subject to 20% <u>coinsurance</u>, <u>deductible</u> waived.</p> <p>Limited to 24 visits / year for all complementary care services combined.</p> <p>*Blue Distinction Total Care (BDTC) <u>providers</u> are <u>preferred providers</u> who have entered into an additional contract with us to take extra measures aimed at improving the quality of care for our members while controlling costs.</p>
	<u>Specialist</u> visit	\$25 <u>copay</u> / visit for BDTC* <u>providers</u> , <u>deductible</u> does not apply; \$50 <u>copay</u> / visit for all other <u>providers</u> , <u>deductible</u> does not apply; other services 20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	No charge	40% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	40% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	\$20 / retail prescription \$30 / mail order prescription			Your prescription drug coverage is administered through OptumRx. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information. Coverage is limited to a 30-day supply retail; 90-day supply mail order or 30-day supply injectable and <u>specialty drugs</u> .
	Preferred brand drugs	\$40 / retail prescription \$60 / mail order prescription			
	Non-preferred brand drugs	\$60 / retail prescription \$90 / mail order prescription			
	<u>Specialty drugs</u>	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% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u> for ambulatory surgery center physicians; 20% <u>coinsurance</u> for all other physicians	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$250 <u>copay</u> / visit, <u>deductible</u> does not apply	20% <u>coinsurance</u> after \$250 <u>copay</u> / visit, <u>deductible</u> does not apply	20% <u>coinsurance</u> after \$250 <u>copay</u> / visit, <u>deductible</u> does not apply	<u>Copayment</u> applies to the facility charge for each visit (waived if admitted).
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	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> above.			None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$12 <u>copay</u> / office/psychotherapy visit for BDTC* <u>providers</u> ; \$25 <u>copay</u> /office/psychotherapy visit for all other <u>providers</u> ; other services 20% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	\$25 <u>copay</u> / office/psychotherapy visit; other services 20% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	40% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	<u>Copayment</u> applies to each <u>preferred</u> and participating <u>provider</u> outpatient office/psychotherapy visit only. All other outpatient services are covered at the <u>coinsurance</u> specified. *See page 2 for a description of a BDTC <u>provider</u> .
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 180 visits / year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Inpatient limited to 30 days / year. Outpatient limited to 25 visits / year. Includes physical therapy, occupational therapy and speech therapy services.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Outpatient neurodevelopmental therapy is limited to 25 visits / year for individuals through age 17. Includes physical therapy, occupational therapy and speech therapy services.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 inpatient days / year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 wig / year.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Respite care is limited to 180 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.)

- |   |                        |  |
|---|------------------------|--|
| • Bariatric surgery                             | • Long-term care       | • Routine eye care (Adult)                     |
| • Cosmetic surgery, except congenital anomalies | • Private-duty nursing | • Routine foot care                            |
| • Dental care (Adult)                           |                        | • Weight loss programs, unless required by law |

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

- |   |  |  |
|---|--|--|
| • Acupuncture                                 | • Hearing aids for individuals 18 or younger or for enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution | • Infertility treatment                              |
| • Alternative care, spinal manipulations only |  | • 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](http://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 x61565 or [cciio.cms.gov](http://cciio.cms.gov) or your state insurance department. You may also contact the plan at 1 (866) 240-9580. 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](http://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 (866) 240-9580 or visit [regence.com](http://regence.com) or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform). You may also contact the Oregon Division of Financial Regulation by calling (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/gethelp/Pages/file-a-complaint.aspx](http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx); or by E-mail at: [cp.ins@oregon.gov](mailto:cp.ins@oregon.gov).

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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 (866) 240-9580.

-----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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,143
What isn't covered	
Limits or exclusions	\$96
The total Peg would pay is	\$3,739

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$6,241
The total Joe would pay is	\$6,461

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,820

## NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### **Regence:**

**Provides free aids and services to people with disabilities to communicate effectively with us, such as:**

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

**Provides free language services to people whose primary language is not English, such as:**

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

### **Medicare Customer Service**

1-800-541-8981 (TTY: 711)

### **Customer Service for all other plans**

1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

### **Medicare Customer Service**

Civil Rights Coordinator

MS: B32AG, PO Box 1827

Medford, OR 97501

1-866-749-0355, (TTY: 711)

Fax: 1-888-309-8784

medicareappeals@regence.com

### **Customer Service for all other plans**

Civil Rights Coordinator

MS CS B32B, P.O. Box 1271

Portland, OR 97207-1271

1-888-344-6347, (TTY: 711)

CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW,  
Room 509F HHH Building  
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.



## Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' 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 ដោយមិនគិតល្អិត គឺអាចមានសំរាប់អ្នក។ 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 ሊያገዝዎት 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 (टिक्टाइप: 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)

ប្រៃសណីយ៍: ថ្នាំថា វាមានជាភាសា ខ្មែរ, ការបំរើការងារឆ្លើយតបភាសា, ដោយឥតគិតថ្លៃ, ដល់អ្នកដែលមានបញ្ហា។ 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 711 TTY)





The Summary of Benefits and Coverage (SBC) document will help you choose a vision plan. The SBC shows you how you and the plan would share the cost for covered vision 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 [regence.com](http://regence.com). For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions, call Regence at 1 (866) 240-9580. 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](http://healthcare.gov/sbc-glossary) or call 1 (866) 240-9580 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not applicable.	See the chart below for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No.	See the chart below for your costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this plan?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://vsp.com">vsp.com</a> or call 1 (844) 299-3041 for lists of VSP doctors or <u>out-of-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from an <u>out-of-network provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ).
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor	Out-of-network Provider	
If you visit a vision care <u>provider's</u> office or clinic	Routine vision examination and vision hardware	No charge up to the VSP doctor limit	No charge up to the out-of- <u>network provider</u> limit	<p>Routine examination limited to 1 every calendar year, and limited to \$45 for an <u>out-of-network provider</u>.</p> <p>Coverage for frames limited to every calendar year. Frame or elective contact lens* allowance is limited to \$250 from VSP doctors. Frame allowance is limited to \$135 for VSP approved wholesale/retail vendor.</p> <p>Coverage for lenses limited to 1 pair (2 lenses) for glass or plastic single vision lenses, lined bifocal lenses, lined trifocal lenses, lenticular lenses, standard progressive lenses or elective contact lenses* every calendar year.</p> <p>Vision hardware allowance from an <u>out-of-network provider</u> is limited to: \$70 for frames, \$30 for single vision lenses, \$50 for lined bifocal / standard progressive lenses, \$65 for lined trifocal lenses, \$100 for lenticular lenses, \$105 for elective contacts (includes fitting/evaluation services)*, or \$210 for necessary contact lenses (includes fitting/evaluation services).</p> <p>*Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any frames and/or lenses until the next calendar year.</p>
	Contact lens evaluation and fitting examination	\$60 <u>copay</u>	No charge up to the <u>out-of-network provider</u> limit*	<p>Limited to 1 contact lens evaluation and fitting examination every calendar year.</p> <p>*Coverage from an <u>out-of-network provider</u> is included in the elective contact lens or necessary contact lens allowance described above.</p>
	Low vision supplemental testing	No charge	No charge up to the <u>out-of-network provider</u> limit	Supplemental testing allowance is limited to \$125 for <u>out-of-network providers</u> .

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor	Out-of-network Provider	
	Low vision supplemental aids	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Supplemental testing and supplemental aids is limited to a combined maximum of \$1,000 once every 2 calendar years.
If your child needs eye care	Children's eye exam	No charge	50% <u>coinsurance</u>	Limited to 1 routine exam / year for individuals under age 19.
	Children's glasses	No charge	50% <u>coinsurance</u>	Limited to 1 pair of lenses (2 lenses) and 1 frame / year for individuals under age 19. Frames from a VSP Doctor are limited to the Otis & Piper Eyewear Collection. In lieu of eyeglasses, you may choose from one of the following elective contact lens types: <ul style="list-style-type: none"> <li>• Standard (one pair annually)</li> <li>• Monthly (six-month supply)</li> <li>• Bi-weekly (three-month supply)</li> <li>• Dailies (three-month supply)</li> </ul>

#### Excluded Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
<ul style="list-style-type: none"> <li>• Corrective vision treatment of an experimental nature</li> <li>• Cosmetic services and supplies</li> <li>• Fees, taxes, interest</li> </ul>	<ul style="list-style-type: none"> <li>• Medical or surgical treatment of the eyes</li> <li>• Non-direct patient care</li> <li>• Orthoptics or vision training</li> </ul>	<ul style="list-style-type: none"> <li>• Personal comfort items</li> <li>• Plano lenses</li> <li>• Two pair of glasses in lieu of bifocals</li> </ul>	

# NONDISCRIMINATION NOTICE

VSP provides administration for your Regence vision plan. 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:

## **VSP**

1-800-877-7195 (TTY: 1-800-428-4833)

If you believe that VSP or 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:

## **Regence**

### **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 1-800-877-7195 (TTY: 800-428-4833).

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 1-800-877-7195 (TTY: 800-428-4833)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-877-7195 (TTY: 800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-877-7195 (TTY: 800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-877-7195 (TTY: 800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-877-7195 (телетайп: 800-428-4833).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-877-7195 (ATS : 800-428-4833)

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。1-800-877-7195 (TTY: 800-428-4833) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yánílti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-877-7195 (TTY: 800-428-4833).

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 1-800-877-7195 (TTY: 800-428-4833)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-877-7195 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 800-428-4833)

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អៀល គឺអាចមានសរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-877-7195 (TTY: 800-428-4833)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-877-7195 (TTY: 800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-800-877-7195 (TTY: 800-428-4833)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነጻ ሊያግዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-800-877-7195 (መስማት ለተሳናቸው:- 800-428-4833)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-877-7195 (телетайп: 800-428-4833)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-877-7195 (टिपिवाइ: 800-428-4833)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-877-7195 (TTY: 800-428-4833)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-877-7195 (TTY: 800-428-4833)

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បែបទុប: វ៉ាវ៉ា ហ៊ានវ៉ាឃាសា ឆាវ, ការបំណិការឆ្ងាយធ្វើចំណងឃាសា, ពែយបំនើឆ្ងាវ, ឆេវ៉ាមីឆ្ងាវពែវ៉ាវ៉ា. ហែវ 1-800-877-7195 (TTY: 800-428-4833)

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