



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to <https://regence.com> or call 1 (888) 367-2117. 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](https://www.healthcare.gov/sbc-glossary) or call 1 (888) 367-2117 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$1,500 individual / \$3,000 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Certain <u>preventive care</u> , <u>prescription drug coverage</u> and those services listed below as " <u>deductible</u> does not apply."	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="https://www.healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$4,500 individual / \$9,000 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://regence.com/go/ID/Preferred">https://regence.com/go/ID/Preferred</a> or call 1 (888) 367-2117 for a list of <u>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 a <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 an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge / office visit, <u>deductible</u> does not apply;  30% <u>coinsurance</u> for all other services	50% <u>coinsurance</u>	<u>Copayment</u> or no charge applies to each in- <u>network provider</u> office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	<u>Specialist</u> visit	\$40 <u>copay</u> / office visit, <u>deductible</u> does not apply;  30% <u>coinsurance</u> for all other services	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u>	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge, <u>deductible</u> does not apply for the first \$400 / year, then 30% <u>coinsurance</u> for outpatient services;  30% <u>coinsurance</u> for inpatient services	No charge, <u>deductible</u> does not apply for the first \$400 / year, then 50% <u>coinsurance</u> for outpatient services;  50% <u>coinsurance</u> for inpatient services	Once outpatient <u>diagnostic tests</u> and imaging combined reach \$400 / year, services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)	No charge, <u>deductible</u> does not apply for the first \$400 / year, then 30% <u>coinsurance</u> for outpatient services;  30% <u>coinsurance</u> for inpatient services	No charge, <u>deductible</u> does not apply for the first \$400 / year, then 50% <u>coinsurance</u> for outpatient services;  50% <u>coinsurance</u> for inpatient services	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="https://regence.com/go/2024/ID/3tier">https://regence.com/go/2024/ID/3tier</a></p>	Tier 1 (Typically, generic drugs with highest overall value)	<p>\$10 <u>copay, deductible</u> does not apply / retail prescription;</p> <p>\$30 <u>copay, deductible</u> does not apply / home delivery prescription</p>	<p>\$10 <u>copay, deductible</u> does not apply / retail prescription;</p> <p>\$30 <u>copay, deductible</u> does not apply / home delivery prescription</p>	<p><u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. No charge, <u>deductible</u> does not apply for drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List.</p> <p>90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply)</p> <p>90-day supply / home delivery prescription</p> <p>30-day supply / <u>specialty drug</u> prescription</p> <p><u>Specialty drugs</u> are not available through home delivery.</p> <p>Coverage includes compound medications at 50% <u>coinsurance</u>.</p> <p><u>Cost shares</u> for tier 2 insulin will not exceed \$100 / 30-day supply retail prescription or \$300 / 90-day supply home delivery prescription.</p> <p>No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy.</p> <p>If you fill a brand drug or <u>specialty drug</u> when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the <u>copayment</u> and/or <u>coinsurance</u>.</p> <p>The first fill of <u>specialty drugs</u> for hemophilia may be provided by a retail pharmacy; additional fills must be provided by a specialty pharmacy or a specialty pharmacy designated as a hemophilia treatment center.</p>
	Tier 2 (Typically, brand drugs with moderate overall value)	<p>\$35 <u>copay, deductible</u> does not apply / retail prescription;</p> <p>\$105 <u>copay, deductible</u> does not apply / home delivery prescription</p>	<p>\$35 <u>copay, deductible</u> does not apply / retail prescription;</p> <p>\$105 <u>copay, deductible</u> does not apply / home delivery prescription</p>	
	Tier 3 (Typically, brand drugs with lower overall value)	<p>\$50 <u>copay, deductible</u> does not apply / retail prescription;</p> <p>\$150 <u>copay, deductible</u> does not apply / home delivery prescription</p>	<p>\$50 <u>copay, deductible</u> does not apply / retail prescription;</p> <p>\$150 <u>copay, deductible</u> does not apply / home delivery prescription</p>	
	<u>Specialty drugs</u>	Refer to tier 1, 2 and 3 drugs above.	90% <u>coinsurance, deductible</u> does not apply / <u>specialty drug</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> for ambulatory surgery centers;  30% <u>coinsurance</u> for all other facilities	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u> for ambulatory surgery center physicians;  30% <u>coinsurance</u> for all other physicians	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u> after \$100 <u>copay</u> / visit	30% <u>coinsurance</u> after \$100 <u>copay</u> / visit	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$40 <u>copay</u> / office visit, <u>deductible</u> does not apply;  30% <u>coinsurance</u> for all other services	50% <u>coinsurance</u>	<u>Copayment</u> applies to each <u>in-network provider</u> office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <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	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	130 visits / year
	<u>Rehabilitation services</u>	\$30 <u>copay</u> / outpatient visit, <u>deductible</u> does not apply; 30% <u>coinsurance</u> for inpatient services	50% <u>coinsurance</u>	22 inpatient days / year 30 outpatient visits / year <u>Copayment</u> applies to each in-network provider outpatient visit only. All inpatient services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . Includes physical therapy, occupational therapy and speech therapy.
	<u>Habilitation services</u>	\$30 <u>copay</u> / office visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	28 neurodevelopmental visits / year Neurodevelopmental therapy limited to individuals under age 7. <u>Copayment</u> applies to each in-network provider office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . Includes physical therapy, occupational therapy and speech therapy.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 inpatient days / year
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u>	14 respite inpatient or outpatient days / lifetime
	<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered
Children's glasses		Not covered	Not covered	
Children's dental check-up		Not covered	Not covered	

## 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.)

- Abortion, except when performed to preserve the life of the enrolled individual
- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care, except for diabetic patients
- Weight loss programs

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

- Acupuncture, 18 visits / year
- Chiropractic care, 18 spinal manipulations / year
- Hearing aids (individuals under age 26), 1 per ear / year
- 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 ext. 61565 or [cciio.cms.gov](http://cciio.cms.gov) or your state insurance department. You may also contact the [plan](#) at 1 (888) 367-2117. 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 (888) 367-2117 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 Idaho Department of Insurance by calling 1 (208) 334-4250 or the toll-free message line at 1 (800) 721-3272; by writing to the Idaho Department of Insurance, Consumer Affairs, 700 W State Street, 3rd Floor; P.O. Box 83720, Boise, ID 83720-0043; through the Internet at: [doi.idaho.gov](http://doi.idaho.gov); or by E-mail at: [consumeraffairs@doi.idaho.gov](mailto:consumeraffairs@doi.idaho.gov).

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

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

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

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

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1 (888) 367-2117.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**About these Coverage Examples:**



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

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

- **The plan's overall deductible** \$1,500
- **Specialist copayment** \$40
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

*Cost Sharing*

<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$3,000

*What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$4,560</b>
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**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$1,500
- **Specialist copayment** \$40
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

*Cost Sharing*

<u>Deductibles</u>	\$800
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0

*What isn't covered*

Limits or exclusions	\$200
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<b>The total Joe would pay is</b>	<b>\$1,200</b>
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**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$1,500
- **Specialist copayment** \$40
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

**This EXAMPLE event includes services like:**

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

*Cost Sharing*

<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$200

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$1,900</b>
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The plan would be responsible for the other costs of these EXAMPLE covered services.





**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 <https://regence.com>. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions call Regence at 1 (888) 367-2117. 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](https://healthcare.gov/sbc-glossary) or call 1 (888) 367-2117 to request a copy.**

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$0	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Not applicable.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://regence.com/go/ID/VSPNetwork">https://regence.com/go/ID/VSPNetwork</a> or call 1 (844) 299-3041 for a list of VSP doctors.	This <u>plan</u> uses a vision <u>provider network</u> (Vision Service Plan). You will pay less if you use a vision <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network</u> vision <u>provider</u> , and you might receive a bill from a vision <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ).
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you visit a vision care <u>provider's</u> office or clinic</b></p>	Routine vision examination	No charge	No charge up to the <u>out-of-network provider</u> limit	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>1 routine eye examination / calendar year Routine eye examination limited to \$45 for <u>out-of-network providers</u>.</p>
	Vision hardware	No charge up to the VSP doctor limit	No charge up to the <u>out-of-network provider</u> limit	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>1 pair of frames / calendar year Frames limited to \$250 for VSP doctors. Frames limited to \$135 for VSP approved wholesale/retail vendors. Frames limited to \$70 for <u>out-of-network providers</u>.</p> <p>1 pair of standard glass or plastic lenses / calendar year for either: Single vision lenses; Lined bifocal (or standard progressive) lenses; Lined trifocal lenses; Lenticular lenses; or Contact lenses*.</p> <p>Elective contact lenses* limited up to \$250 for VSP doctors. Necessary contact lenses* limited to a calendar year supply for VSP doctors.</p> <p>Single vision lenses limited to \$30 for <u>out-of-network providers</u>. Lined bifocal (or standard progressive) lenses limited to \$50 for <u>out-of-network providers</u>. Lined trifocal lenses limited to \$65 for <u>out-of-network</u></p>

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				<p><u>providers</u>. Lenticular lenses limited to \$100 for <u>out-of-network providers</u>. Elective contact lenses* (including fitting/evaluation services) limited to \$105 once / calendar year for <u>out-of-network providers</u>. Necessary contact lenses* (including fitting/evaluation services) limited to a calendar year supply up to \$210 for <u>out-of-network providers</u>.</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 or other types of 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>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>1 contact lens evaluation and fitting examination / calendar year Elective contact lens evaluation and fitting examination (including elective contact lenses) limited to \$105 for <u>out-of-network providers</u>. Necessary contact lens evaluation and fitting examination (including necessary contact lenses) limited to \$210 for <u>out-of-network providers</u>.</p>

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Low vision supplemental examinations (testing)	No charge	No charge up to the <u>out-of-network provider limit</u>	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>\$1,000 low vision maximum / 2 calendar years, including supplemental examinations (testing) and care aids</p> <p>2 supplemental examinations / 2 calendar years</p> <p>Supplemental examinations limited to \$125 for <u>out-of-network providers</u>.</p>
	Low vision supplemental care aids	25% <u>coinsurance</u>	25% <u>coinsurance</u>	

**Excluded 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.)**

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"><li>• Corrective vision treatment of an experimental nature</li><li>• Cosmetic services and supplies</li></ul> | <ul style="list-style-type: none"><li>• Fees, taxes and interest</li><li>• Medical or surgical treatment of the eyes</li><li>• Non-direct patient care</li></ul> | <ul style="list-style-type: none"><li>• Orthoptics or vision training</li><li>• Plano lenses</li><li>• Two pair of glasses in lieu of bifocals</li></ul> |
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## NONDISCRIMINATION NOTICE

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

### **Regence:**

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

### **Medicare Customer Service**

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

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

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

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

### **Medicare Customer Service**

Civil Rights Coordinator

MS: B32AG, PO Box 1827

Medford, OR 97501

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

Fax: 1-888-309-8784

medicareappeals@regence.com

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

Civil Rights Coordinator

MS CS B32B, P.O. Box 1271

Portland, OR 97207-1271

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

CS@regence.com

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

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

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

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

## Language assistance

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

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

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

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

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

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

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

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

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ 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 (टिडिवाइ: 711)

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

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີຜ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajjila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

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