THE EMPLOYMENT COMMONS

2020 BENEFIT ENROLLMENT GUIDE

2020 BENEFITS GUIDE

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EMPLOYMENT COMMONS BENEFITS

The benefit programs offered are designed to support the needs of community employees and their dependents by providing a benefits package that is easy to understand, easy to access and affordable.

This summary will help you choose the type of plan and level of coverage that is right for you and your family.

Do you know all of the options that are available to you?

- Three (3) medical plans for you to choose the best option for you and your family
- A spouse's or domestic partner's plan
- Coverage through your state Health Insurance Marketplace. You can find information about your state's marketplace at www.healthcare.gov (created as part of healthcare reform)
- Medicaid or other federal assistance programs for low-income families
- Medicare if you are age 65 or older
- Individual market

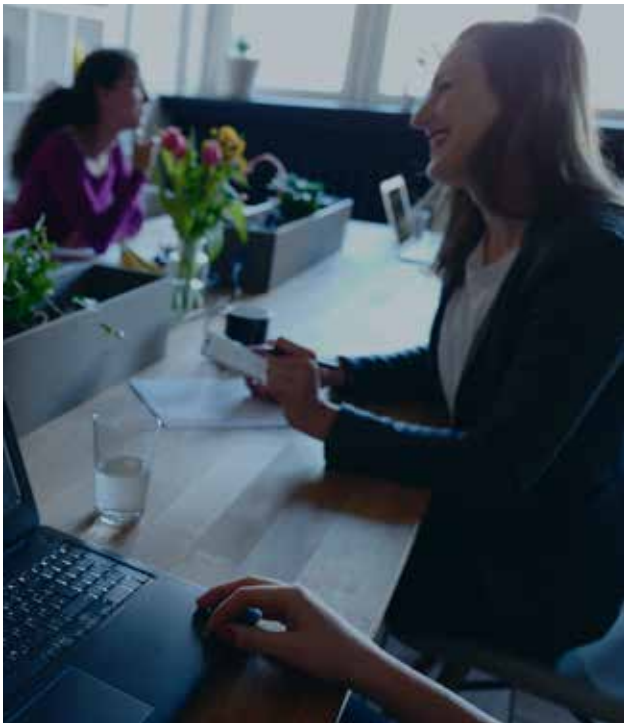
Understanding what might be available to you and if you are eligible to participate can help you make the best choices for you and your family.

Individual Mandate: The Affordable CARE Act requires most individuals to obtain acceptable health insurance coverage for themselves and their family members; in prior years if coverage was not elected a tax penalty was assessed. However, the penalty has been waived starting in 2019.

ELIGIBILITY & ENROLLMENT

WHO IS ELIGIBLE?

We are proud to offer a comprehensive benefits package to all eligible, full-time employees who work 30 hours or more per week. Eligible dependents are your legal spouse, children up to age 26, or disabled dependents of any age.



MAKING CHANGES (QUALIFING EVENTS)

Elections made now will remain until the next annual enrollment unless you or your family members experience a qualifing event. If you experience a qualified event, you must contact The Employment Commons HR within 30 days. With eligibility for Medicaid or CHIP or termination of Medicaid or CHIP, you have 60 days to contact The Employment Commons HR. Written documentation supporting your eligibility to make changes may be required. Qualified events are defined as:

- Marriage, divorce, or legal separation
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, marriage, or reaching the dependent-child age limit
- Changes in your dependent's employment affecting benefits eligibility
- Changes in your dependent's benefit coverage with another employer that affects benefits eligibility

MEDICAL COVERAGE

Choosing the right health plan is one of the most important decisions you can make for you and your family. It is the objective of the The Employment Commons Community to provide an employee benefits program that makes it easy for you and your dependents to access the medical care you need. Please carefully consider the three medical plans (in partnership with Blue Cross Blue Shield) to make the best medical choices for you and your family.

PLAN OPTIONS

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. The Employment Commons offers you the choice of three medical plans:

1. **Gold 500 FSA + Vision**
2. **Silver 4250 HSA + Vision**
3. **Bronze 5000 HSA + Vision**

PPO PLANS (GOLD 500 FSA + VISION)

A PPO plan provides both in and out of network coverage, however, you save the most money when you seek services from an in-network provider. A PPO plan covers preventive care at 100% resulting in no out-ofpocket costs to you. The most commonly used services, such as office visits, urgent care, and prescription drugs are not subject to the deductible and you are only subject to a copay. Higher costs services, such as imaging, inpatient hospitalization, and outpatient surgery require you to meet your annual deductible before receiving coverage.

HIGH DEDUCTIBLE HEALTH PLAN - HDHP (BRONZE 5000 HSA + VISION SILVER 4250 HSA + VISION)

A HDHP (High Deductible Health Plan) provides both in-and out-of-network benefits, similar to a PPO plan, however, you must meet your deductible before insurance will begin to pay for covered services, except for preventive care which is covered at 100%. The HDHP option is a qualified plan for a Health Savings Account (HSA). With an HSA, you are able to set aside pre-tax funds into an account to be used for qualified medical, dental, and vision expenses. For more information on how your HSA works, please see the HSA section of this booklet.

TERMS YOU SHOULD KNOW

Deductible: This is the amount you must pay each calendar year before the plan begins to pay for certain benefits.

Co-payment/Copay: This is the fee you must pay under your plan each time you go to a doctor or hospital for certain services. A copay is also required for prescription drugs.

Co-Insurance: This is the percentage of cost that you pay for covered services after you have met the deductable.

Out-of-Pocket Max: The plan limits the amount of money you will have to pay each year for covered expenses. Once you reach this dollar limit, the plan generally pays 100% of eligible expenses for the rest of the calendar year.

IN NETWORK	GOLD 500 FSA + VISION	SILVER 4250 HSA + VISION	BRONZE 5000 HSA + VISION
Annual Deductible:			
Sole Coverage Only	$500	$4,250	$5,000
Individual Member of Family	$1,000	$8,150	$8,150
Combined Family	$1,000	$8,500	$10,000
Out-of-Pocket Max:			
Sole Coverage Only	$6,500	$4,250	$6,900
Individual Member of Family	$13,000	$8,150	$8,150
Combined Family	$13,000	$8,500	$13,800
Primary Care Physician	$30 Copay	Covered In Full After Ded.	$40 Copay After Ded.
Specialist	$50 Copay	Covered In Full After Ded.	$60 Copay After Ded.
Preventive Care	Covered in full	Covered In Full	Covered in full
Basic Lab / X-ray services	30% Coinsurance	Covered In Full After Ded.	50% After Ded.
Advanced Imaging (CT/PET Scans, MRI's)	30% After Ded.	Covered In Full After Ded.	50% After Ded.
Inpatient	30% After Ded.		50% After Ded.
Outpatient	30% After Ded.		50% After Ded.
Urgent Care	$50 Copay		$60 Copay After Ded.
Emergency Room	$300 Copay then In-Network Ded.	Covered In Full After Ded. for all	50% After Ded.
Telehealth	$10 Copay		$10 Copay After Ded.
Acupuncture & Spinal Manipulation	$30 Copay ($1,000 Annual Limit)	($1,000 Annual Limit)	$40 Copay After Ded. ($1,000 Annual Limit)
Prescription Drug Benefits: Preferred Generic / Non Preferred Generic / Preferred Brand / Non Preferred Brand / Preferred Specialty / Non Preferred Specialty	Retail: $10 / 25% / $50 / 50% / 20% / 50% Mail Order: $20 / 20% / $100 / 45% - Specialty Excluded	Retail: Covered In Full After Ded. Mail Order: up to a 90 day supply - Specialty Excluded	Retail: After Ded. 50% / 50% / 50% / 50% / 20% / 50% Mail Order: 45% / 45% / 45% / 45% - Specialty Excluded
OUT OF NETWORK	**GOLD 500 FSA + VISION**	**SILVER 4250 HSA + VISION**	**BRONZE 5000 HSA + VISION**
Annual Deductible (Sole-Coverage / Family)	$5,000 / $10,000	$5,000 / $10,000	$10,000 / $20,000
Out-of-Pocket Max (Sole-Coverage / Family)	$10,000 / $20,000	$10,000 / $20,000	$15,000 / $30,000
Primary Care / Specialty	50% After Ded.	50% After Ded.	50% After Ded.
Prescription Drug Benefits: Preferred Generic / Non Preferred Generic / Preferred Brand / Non Preferred Brand / Preferred Specialty / Non Preferred Specialty	No coverage for prescription drugs not on the Drug List. No coverage for prescription drugs from an out-of-network pharmacy.		
	Click for full plan details	**Click for full plan details**	**Click for full plan details**

HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS A HEALTH SAVING ACCOUNT?

A Health Savings Account (HSA) is an individually-owned, tax-advantaged account that you can use to pay for current or future IRS qualifiedmedical expenses. With an HSA, you'll have the potential to build more savings for healthcare expenses or additional retirement savings through self-directed investment options.

HOW DO HSA ACCOUNTS WORK?

You can contribute to your HSA via payroll deductions, online banking transfer, or send a personal check. Your employer or third party, such as a spouse or parent, may contribute to your account as well.

You can pay for qualified medical expenses with your Health Benefits Debit Card directly to your medical provider or pay our-of-pocket. You can either choose to reimburse yourself or keep the funds in your HSA to grow your savings.

Unused funds will roll over year to year. After age 65, funds may be withdrawn for any purpose without a penalty (subject to ordinary income taxes). Check balances and account information via HealthEquity website at www.healthequity.com or use their mobile app 24/7.

ARE YOU ELIGIBLE FOR AN HSA?

You can open and contribute to an HSA if you meet the following criteria:

1. Are covered by an HSA-qualified health plan (HDHP);
2. Are not covered by other health insurance (with some exceptions);
3. Are not enrolled in Medicare;
4. Are not enrolled in TriCare;
5. Are not eligible to be claimed as a dependent on another person's tax return (unless it's your spouse);
6. Have not received health benefits from the Veterans Administration with the exception of services for a "service related disability" or an Indian Health Services facility within the last three months; and
7. Are not covered by your own or your spouse's general purpose Healthcare.

IRS LIMITS ON ANNUAL DEPOSITS

Any contributions made by all parties can not exceed the IRS annual HSA limit. Below are the IRS limit amounts for the 2020 calendar year.

MAXIMUM CONTRIBUTION:
Individual $3,550 / Family $7,100

HEALTH SAVINGS ACCOUNT (HSA)

CONTRIBUTING TAX FREE EARNINGS INTO YOUR HSA

If you enroll in the High Deductible Health Plan mid-plan year, you may contribute the maximum calendar year amount to your HSA as long you maintain continuous HDHP enrollment for a 12-month period. The 12-month period starts with the last month of the taxable year and ends 12 months later. If you do not remain continuously enrolled in an HDHP for the 12-month period, your maximum contribution will be less than the maximum calendar year amount and you may be subject to additional IRS taxes and penalties. Please consult your tax advisor for information.

Catch-up contributions for employee's age 55 or older, who are not enrolled in Medicare, may contribute an additional $1,000 to their HSA account. Spouses who are 55 or older and covered under the employee's medical insurance may also make a catch-up contribution into a separate HSA account in their own name. If you enroll in Medicare mid-year, your catch-up contribution should be prorated.

SPENDING YOUR HSA DOLLARS, EXAMPLES INCLUDE*:

Alcoholism treatment
Acupuncture
Ambulance service
Artificial limb or prosthesis
Birth control pills (by prescription)
Chiropractor
Childbirth/ delivery
Doctor's fees (copay, etc.)
Dental treatments
Dermatologist
Diagnostic services
Disabled dependent care
Drug addiction therapy
Fertility enhancement
(including in-vitro fertilization)
Gynecologist
Guide dog (or other service animal)
Hearing aids and batteries
Hospital bills
Laboratory fees
Lactation expenses
Lodging (away outpatient care)
Nursing home & Nursing services
Obstetrician
Osteopath
Oxygen
Pregnancy test kit
Podiatrist
Prescription drugs and medicines
Prenatal care & postpartum treatment
Psychiatrist & Psychologist
Smoking cessation programs
Special education tutoring
Equipment to assist hearing or vision impaired
Therapy or counseling
Medical transportation expenses
Transplants
Vaccines
Vision care
Lasik surgery
Weight loss programs
Wheelchair
Retirement

***This is not a comprehensive list of IRS qualified expenses. For more information, please refer to the IRS publication 502 titled "Medical and Dental Expenses".**

DENTAL COVERAGE

UNITED HEALTHCARE DPO

Annual Deductible: Individual $50 / Family $150 Max

100% Preventive / 80% Basic / 50% Major Care
Endo and Perio in Basic
$1,000 Annual Maximum Included
Maximum Rollover In
No Wait for Major Care
Child Orthodontia - $1,000 Lifetime Max

Get rewarded for taking care of your smile:

• Earn award dollars for visiting your dentist at least once a year.
• Your award dollars will help to pay for claims that go beyond your annual maximum.
• Unused award dollars can roll over each year.

How your dollars add up:
This year's annual maximum is $1,000
If your total claims are less than $500
You'll earn a reward of $250

Plus, if you have a Dental PPO plan and all claims are with network dentists, you'll earn an extra $100. Your award dollars will be added to next year's annual maximum to pay for qualifying claims.

Good oral care enhances overall physical health, appearance and mental well-being.

We offer competitive benefits designed to provide high quality dental care. Problems with the teeth and gums are common and many of these issues are easily treated health problems. You and your family members may visit any licensed dentist and will receive the greatest out-of-pocket savings if you see an in-network dentist.

If you choose to see an out-of-network dentist, you can incur additional out-of pocket expenses due to lower plan reimbursement levels and if your provider balance bills you for the difference between what the plan pays and their submitted fee. When you see an in-network Dentist, you are protected from balance billing. Ask your dentist if they are "In-Network" or go to the carrier website and search for in-network providers.

Our Consumer MaxMultiplier® program rewards you for keeping up with your dental care by adding dollars to next year's annual maximum. And it's included as part of your dental plan.

Program rules:

1. $1,000 is the most award dollars that can be rolled over to the annual maximum. The total annual maximum cannot go above $2,000.
2. If your plan has different annual network and out-of-network maximums, the award dollars will be based on the annual out-of-network maximum.
3. Award dollars can be used for claims filed up to 180 days after your benefit period ends.
4. Award dollars can be used for both network and out-of-network claims.
5. Award dollars do not apply to orthodontic services.
6. If you sign up for a UnitedHealthcare Dental PPO or Dental In-Network Only (INO) plan in the last three months of a benefit period, you will have to wait until the end of the first full month of the next benefit period to participate in this program.
7. If you end your coverage, but sign up again within six months with the same employer, you can keep your award balance as long as your employer still offers a dental plan with Consumer MaxMultiplier. If six months or more pass, you will lose the award balance.
8. If your employer decides to change your dental plan, your award balance will move with you as long as the new plan includes Consumer MaxMultiplier.

View your annual maximum balance on www.myuhc.com. You will not actually earn cash that you can access or withdraw. UnitedHealthcare adds the award dollars to your annual maximum for the following year and applies them to qualifying claims.

PEDIATRIC DENTAL COVERAGE ALREADY INCLUDED UNDER ALL THREE MEDICAL PLANS	
Covered for members up to age 19 **Member's coinsurance amounts apply to in-network medical out-of-pocket maximum** **Various limits apply**	
Preventive and Diagnostic Services	• X-rays: —Routine radiology: 1 (set) per calendar year —Bitewing x-ray series: 1 (set) per calendar year —Panoramic or intra-oral complete series: Once every 5 calendar years • Cleanings: 2 per calendar year • Preventive and diagnostic oral examinations: 2 per calendar year • Topical fluoride application: 2 treatments per calendar year • Sealants (permanent molars): Once per molar during a 5-year period • Space maintainers
Basic Services	• Fillings: Consisting of composite and amalgam restorations • Oral Surgery: Uncomplicated and complex oral surgery procedures • General dental anesthesia or intravenous sedation: Subject to necessity • Emergency treatment for pain relief • Periodontal Maintenance: 2 per calendar year • Periodontal debridement: Once in a 2-year period • Scaling and Root Planing: Once in a 2-year period • Endodontic services including root canal treatment, pulpotomy and apicoectomy
Major Services	• Crowns, inlays and onlays: —Permanent crowns limited to 4 (including replacement crowns) in a 7-year period —Permanent crown replacement limited to once within a 7-year period after placement • Dentures (full or partial) • Bridges (fixed partial denture) • Orthodontia: Covered when medically necessary

VISION COVERAGE

Your eyes can provide a window to your overall health. Through routine exams your provider may be able to detect general health problems in their early stages along with determining if you need corrective lenses.

IN NETWORK	OUT OF NETWORK
Exam Covered in Full / Every Calendar Year Lenses Covered in Full / Every Calendar Year $150 Frame Allowance / Every Calendar Year **Routine vision examination and vision hardware:** No charge up to the VSP doctor limit **Contact lens evaluation and fitting examination:** $60 Copay	**Routine vision examination and vision hardware:** No charge up to the out-of-network provider limit **Contact lens evaluation and fitting examination:** No charge up to the out-of-network provider limit*

Routine vision examination and vision hardware:

- Limited to individuals age 19 or older.
- Routine examination limited to 1 every calendar year and limited to $45 for an out-of-network provider.
- Frame or elective contact lenses* limited to $150 from a VSP doctor / every calendar year; frame allowance limited to $80 from a VSP approved wholesale/retail vendor; and $70 from an out-of-network provider / every calendar year.
- 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.
- Lenses from an out-of-network provider limited to: $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).
- *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.

Contact lens evaluation and fitting examination:

- Limited to individuals age 19 or older.
- Limited to 1 contact lens evaluation and fitting examination every calendar year.
- *Coverage from an out-of-network provider is included in the elective contact lens or necessary contact lens allowance described above.

PEDIATRIC VISION COVERAGE ALREADY INCLUDED UNDER ALL THREE MEDICAL PLANS	
Covered for members up to age 19 **Uses the VSP Choice network of providers**	
Eye Exam	One routine eye exam per calendar year
Hardware	• One pair of standard lenses per calendar year • Frames from the Otis and Piper Eyewear Collection once per calendar year • Contact lenses once per calendar year (in lieu of all other lenses and frames)

FLEXIBLE SPENDING ACCOUNTS (FSA)

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

Flexible Spending Accounts (FSAs) allow employees to use pretax dollars for healthcare and/or child and dependent care expenses not covered by insurance plans. Employees contribute a portion of each paycheck to an FSA and save on taxes. Money in an FSA can be used to pay for out-of pocket medical, dental and vision expenses or dependent care expenses. The FSA Plan Year is January 1st through December 31st. The funds are subject to the "use it or lose it" rule. The Employment Commons offers two Health Flexible Spending Accounts: Healthcare FSA and Limited Purpose FSA, and also a third type called Dependent Care FSA. All three types are defined below.

HEALTHCARE FSA

is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. It's a smart, simple way to save money while keeping you and your family healthy and protected. The IRS sets a limit on how much you can contribute to this account each year. For 2020, the spending limit is $2,750.

LIMITED PURPOSE HEALTHCARE FSA (LPFSA)

is a flexible spending account that only reimburses you for eligible dental and vision expenses. A LPFSA is available to employees who are enrolled in a high deductible health plan (HDHP) and you may enroll in both the LPFSA and the HSA. By establishing a LPFSA, you can save money on taxes by using your LPFSA dollars for your dental and vision expenses while preserving your HSA funds for other purposes, including simply saving those funds for the future. The IRS sets a limit on how much you can contribute to this account each year. For 2020, the spending limit is $2,750.

DEPENDANT CARE FSA

is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. A Dependent Care FSA is a smart, simple way to save money while taking care of your loved ones so that you can continue to work. The IRS sets a limit on how much you can contribute to this account each year. For 2020, the spending limit is $5,000 if married and filing jointly or head of household or $2,500 if married and filing separately.

HERES HOW AN FSA WORKS:

1. Decide the annual amount you want to contribute based on your expected health care and/or dependent childcare/elder care expenses.
2. Elections are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA. Your entire annual election is available immediately after the beginning of the plan year for the Health Care FSA and LPFSA. For the Dependent Care FSA you can only receive the amount that is in your account when your claim is paid.
3. For eligible Health Care FSA or LPFSA expenses you submit a claim form for reimbursement or file the claim online. For dependent care you pay for eligible expenses when incurred and then submit a reimbursement claim form or file the claim online.
4. You are reimbursed from your FSA so you actually pay your expenses with tax-free dollars.
5. You can use the LPFSA only for dental and vision expenses.
6. Any Healthcare FSA, LPFSA and Dependent Care FSA funds not used by the end of the calendar year will be forfeited.

LIFE & DISABILITY INSURANCE

BASIC LIFE & AD&D

Life/Accidental Death & Dismemberment protects employees and their families from financial hardship in the event of death or dismemberment. It provides the peace of mind you get when you know your loved ones will be protected if anything happens to you.

LIFE/ACCIDENTAL DEATH AND DISMEMBERMENT	
Employee Benefit Amount	$50,000
Spouse Child(ren)	Not Covered Not Covered

SHORT AND LONG TERM DISABILITY

One of the most important assets to you as an employee is the ability to earn an income. The disability program is designed to continue providing you with income if you're unable to work due to sickness or injury. Disability insurance can help you continue to pay your bills by replacing a portion of your income until you are able to return to work.

SERVICES	SHORT TERM DISABILITY	LONG TERM DISABILITY
Benefit Percentage	60%	60%
Benefit Maximum	$750 per week	$5,000 per month
Elimination Period	7 days accident / 7 days sickness	90 days (13 weeks)
Benefit Duration	90 days (13 weeks)	5 years
Pre-Existing Clause	12 months prior / 12 months insured	3 months prior / 12 months insured

THE COMMONS RETIREMENT PLAN

The Commons' 401(K) PLAN IS ADMINISTERED BY SLAVIC 401K: www.slavic401k.com . Please contact the The Employment Commons HR team for further enrollment details.

2020 PREMIUMS - MONTHLY

MEDICAL PRE-TAX	GOLD 500 FSA + VISION	SILVER 4250 HSA + VISION	BRONZE 5000 HSA + VISION
Employee Only	$433.54	$328.07	$265.43
Employee + Spouse	$864.13	$653.19	$527.91
Employee + Child(ren)	$799.54	$604.42	$488.54
Employee + Family	$1,230.13	$929.54	$751.02

DENTAL PRE-TAX	
Employee Only	$42.46
Employee + Spouse	$84.92
Employee + Child(ren)	$99.28
Employee + Family	$149.32

LIFE & AD&D
$7.50 / month

SHORT TERM DISABILITY	LONG TERM DISABILITY	
$0.20 per $10 of Weekly Benefit	Age-Banded Rates per $100 of Covered Payroll	
	Age 0-24	$0.04
	Age 25-29	$0.05
	Age 30-34	$0.07
	Age 35-39	$0.09
	Age 40-44	$0.12
	Age 45-49	$0.17
	Age 50-54	$0.23
	Age 55-59	$0.33
	Age 60-64	$0.40
	Age 65-150	$0.40

LEGAL NOTICE

WOMENS HEALTH AND CANCER RIGHTS ACT

The Women's Health Act of 1998 requires us to notify you that our plans provide benefits for certain breast reconstruction procedures related to a mastectomy. If you elect coverage under the medical plan and you or any covered family member require breast reconstruction related to a mastectomy,
benefits will be provided for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Any deductible, copayments or other plan requirements that normally apply to surgical procedures covered by your health plan will also apply to these procedures.

If you have questions pertaining to this notice, please feel free to contact Human Resources at hr@opolis.co.

NEWBORNS ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or
her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Plans subject to State law requirements will need to prepare SPD statements describing any applicable State law.

HIPAA SPECIAL ENROLLMENT RIGHTS

Loss of Other Coverage — If you are declining enrollment for yourself and/ or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependents' coverage. To be eligible for this special enrollment opportunity
you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption — If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/ or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Our health health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. TERMINATION OF MEDICAID OR SCHIP COVERAGE. If the employee or dependent is covered under a Medicaid plan or under a State child health plan
2. (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
3. ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR SCHIP. If the employee or dependent becomes eligible for premium assistance under
4. Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where
5. the State assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a State Medicaid program.

To be eligible for this special enrollment opportunity, you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date your or your dependents' Medicaid or State sponsored CHIP coverage ends. To request special enrollment or obtain more information, please contact Human Resources at hr@opolis.co.

LEGAL NOTICE

IMPORTANT NOTICE FROM THE EMPLOYMENT COMMONS COMMUNITY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Employment Commons Community and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a highermonthly premium.
2. 2. Prescription drug coverage offered by a group plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Credible Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The Employment Commons Community coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current The Employment Commons Community coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Employment Commons Community and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Employment Commons changes. You also may request a copy of this notice at any time or if you have questions pertaining to this notice, please feel free to contact Human Resources at hr@opolis.co.

LEGAL NOTICE: CONTINUED

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage visitwww.medicare.gov.

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE:

Contact: HR@Opolis.co

LEGAL NOTICE

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at or call www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your state for more information on eligibility.

ALABAMA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA - Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
HFC Website: www.healthfirstcolorado.com/ HFC Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-planplus CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA - Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA - Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premiumpayment-program-hipp Phone: 678-564-1162 ext 2131
INDIANA - Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA - Medicaid
Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS - Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

LEGAL NOTICE: CONTINUED

KENTUCKY - Medicaid

Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA - Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE - Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA - Medicaid

Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI - Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA - Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA - Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA - Medicaid

Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid

Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK - Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA - Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA - Medicaid

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND– Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

LEGAL NOTICE: CONTINUED

TEXAS - Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH - Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT - Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA - Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING - Medicaid
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

IMPORTANT CONTACTS

BENEFIT	CARRIER	CONTACT INFORMATION
Medical	Blue Cross Blue Shield	1.800.810.BLUE (2583) www.bcbs.com
Vision	VSP Choice Network	1.800.810.BLUE (2583) www.bcbs.com
Dental	United Healthcare	1-800-357-0978 www.uhc.com
Basic Life, Voluntary Life, STD & LTD	United Healthcare	1-800-357-0978 www.uhc.com

GOLD 500 FSA + VISION

2020 BENEFIT ENROLLMENT GUIDE

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/go/2020/booklet/OR/Gold500 or call 1 (888) 367-2116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 367-2116 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $500 individual / $1,000 family per calendar year. Out-of-network: $5,000 individual / $10,000 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $6,500 individual / $13,000 family per calendar year. Out-of-network: $10,000 individual / $20,000 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, coinsurance for out-of-network pediatric vision services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See regence.com/go/OR/Preferred or call 1 (888) 367-2116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / office visit $20 copay / office visit at a retail clinic Deductible does not apply for these visits; 30% coinsurance for all other services	50% coinsurance	Copayment applies to each in-network office visit only. All other services that are not billed as an office visit are covered at the coinsurance specified, after deductible. Coverage for acupuncture and chiropractic spinal manipulations is subject to $30 copayment / visit, deductible does not apply. Limited to $1,000 / year for all acupuncture and chiropractic spinal manipulation services combined.
	Specialist visit	$50 copay / office visit Deductible does not apply for these visits; 30% coinsurance for all other services	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance, deductible does not apply for outpatient services	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at regence.com/go/druglist/2020/OR/6tier.	Preferred generic drugs & generic drugs	$10 copay* / preferred retail prescription $20 copay / preferred mail order prescription 25% coinsurance* / retail prescription 20% coinsurance / mail order prescription		No coverage for prescription drugs not on the Drug List. No coverage for prescription drugs from an out-of-network pharmacy. Deductible does not apply. Limited to a 90-day supply retail (1 copayment per 30-day supply), 90-day supply mail order or 30-day supply self-administrable cancer chemotherapy and specialty drugs (including preferred). No charge for FDA-approved women's contraceptives and certain preventive drugs and immunizations at a participating pharmacy. The first fill for designated specialty drugs (including preferred) may be provided at a retail pharmacy, additional refills and any fills for other non-designated specialty drugs (including preferred) must be provided at a specialty pharmacy. Coverage for self-administrable cancer chemotherapy drugs is 30% coinsurance. *Discount of $5 off copayment or 5% off coinsurance when filled at a preferred retail pharmacy.
	Preferred brand drugs	$50 copay* / retail prescription $100 copay / mail order prescription		
	Brand drugs	50% coinsurance* / retail prescription 45% coinsurance / mail order prescription		
	Preferred specialty drugs & specialty drugs	20% coinsurance / preferred retail prescription 50% coinsurance / retail prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance for ambulatory surgery center; 30% coinsurance for all other facilities	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance for ambulatory surgery center physicians; 30% coinsurance for all other physicians	50% coinsurance	None

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 need immediate medical attention	Emergency room care	$300 copay / visit	$300 copay / visit	Copayment applies to the facility charge for each visit (waived if admitted), whether or not the in-network deductible has been met.
	Emergency medical transportation	30% coinsurance	30% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Urgent care	$50 copay / office visit Deductible does not apply for these visits; 30% coinsurance for all other services	50% coinsurance	Copayment applies to each in-network office visit only. All other services that are not billed as an office visit are covered at the coinsurance specified, after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / office visit Deductible does not apply for these visits; 30% coinsurance for all other services	50% coinsurance	Copayment applies to each in-network outpatient office/psychotherapy visit only. All other outpatient services are covered at the coinsurance specified, after deductible.
	Inpatient services	30% coinsurance	50% coinsurance	Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	

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 need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	None
	Rehabilitation services	$30 copay / outpatient visit Deductible does not apply for these visits; 30% coinsurance / inpatient services	50% coinsurance	Limited to 30 inpatient days (up to 60 days for head or spinal cord injury) and 30 outpatient visits each for rehabilitation and habilitation services / year. Includes physical therapy, speech therapy, and occupational therapy. Copayment applies to each in-network outpatient visit only. Inpatient services are covered at the coinsurance specified, after deductible. Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
	Habilitation services	$30 copay / outpatient visit Deductible does not apply for these visits; 30% coinsurance / inpatient services	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 inpatient days / year.
	Durable medical equipment	30% coinsurance	50% coinsurance	Limited to 1 synthetic wig / year and 1 pair of glasses or contacts / year due to severe medical or surgical problem other than refractive procedures.
	Hospice services	30% coinsurance	50% coinsurance	Limited to 30 inpatient or outpatient respite days / lifetime (limited to a maximum of 5 consecutive respite days at a time).
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance, deductible does not apply	Limited to 1 routine examination / year for individuals under age 19. Coinsurance for out-of-network services does not apply to the out-of-pocket limit.
	Children's glasses	No charge	50% coinsurance, deductible does not apply	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. Coinsurance for out-of-network services does not apply to the out-of-pocket limit.
	Children's dental check-up	No charge	No charge	Limited to 2 cleanings and 2 preventive oral examinations / year for individuals under age 19. Additional coverage is provided for basic and major pediatric dental services.

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
- Cosmetic surgery, except for certain situations
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care, including vision hardware (Adult)
- Routine foot care, except for diabetic patients
- 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.)

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 x61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 367-2116. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (888) 367-2116 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling (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; or by E-mail at: DFR.InsuranceHelp@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 (888) 367-2116.

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$500**
Specialist copayment	**$50**
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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$33
Coinsurance	$3,514
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,107**

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

The plan's overall deductible	**$500**
Specialist copayment	**$50**
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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,288
Coinsurance	$31
What isn't covered	
Limits or exclusions	$255
The total Joe would pay is	**$2,574**

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

The plan's overall deductible	**$500**
Specialist copayment	**$50**
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)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$512
Coinsurance	$259
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,271**

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

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

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

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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

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

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

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

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

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

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

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

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. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions, call Regence at 1 (888) 367-2116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 367-2116 to request a copy.

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

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 provider's office or clinic	Routine vision examination and vision hardware	No charge up to the VSP doctor limit	No charge up to the out-of-network provider limit	Limited to individuals age 19 or older. Routine examination limited to 1 every calendar year and limited to $45 for an out-of-network provider. Frame or elective contact lenses* limited to $150 from a VSP doctor / every calendar year; frame allowance limited to $80 from a VSP approved wholesale/retail vendor; and $70 from an out-of-network provider / every calendar year. 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. Lenses from an out-of-network provider limited to: $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). *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.
	Contact lens evaluation and fitting examination	$60 copay	No charge up to the out-of-network provider limit*	Limited to individuals age 19 or older. Limited to 1 contact lens evaluation and fitting examination every calendar year. *Coverage from an out-of-network provider is included in the elective contact lens or necessary contact lens allowance described above.

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 testing	No charge	No charge up to the out-of-network provider limit	Limited to individuals age 19 or older. Supplemental testing allowance limited to $125 for out-of-network providers. Supplemental testing and supplemental aids limited to a combined maximum of $1,000 once every 2 calendar years.
	Low vision supplemental aids	25% coinsurance	25% coinsurance	

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.)

- Corrective vision treatment of an experimental nature
- Cosmetic services and supplies
- Fees, taxes, interest
- Medical or surgical treatment of the eyes
- Non-direct patient care
- Orthoptics or vision training
- Personal comfort items
- Plano lenses
- Two pair of glasses in lieu of bifocals

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
Medicare 1-844-872-6065
Commercial 1-844-299-3041
(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

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.

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: TTY: 1-800-428-4833).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (ATS : 1-800-428-4833)

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。Medicare: 1-844-872-6065; Commercial: 1-844-299-3041（TTY: 1-800-428-4833）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833.)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)¶

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (መስማት ለተሳናቸው:- 1-800-428-4833)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: 1-800-428-4833)

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (टिटिवाइ: 1-800-428-4833

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

MAANDO: To a waawi [Adamawa], e woodi balloojima to ekkitaaki wolde caahu. Noddu Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

Language assistance

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-428-4833)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم Medicare: 1-844-872-6065;
Commercial: 1-844-299-3041
(رقم هاتف الصم والبكم TTY: 1-800-428-4833)

SILVER 4250 HSA + VISION

2020 BENEFIT ENROLLMENT GUIDE

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/go/2020/booklet/OR/SilverHSA4250 or call 1 (888) 367-2116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 367-2116 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $4,250 individual (single coverage) / $8,500 family per calendar year. Out-of-network: $5,000 individual (single coverage) / $10,000 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $4,250 individual (single coverage) / $8,500 family* per calendar year. Out-of-network: $10,000 individual (single coverage) / $20,000 family per calendar year. *A member on family coverage will not have his or her in-network out-of-pocket limit exceed $8,150.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, coinsurance for out-of-network pediatric vision services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See regence.com/go/OR/Preferred or call 1 (888) 367-2116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	50% coinsurance	Coverage includes primary care visits at a retail clinic. Coverage for acupuncture and chiropractic spinal manipulations is subject to 0% coinsurance / visit. Limited to $1,000 / year for all acupuncture and chiropractic spinal manipulation services combined.
	Specialist visit	0% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at regence.com/go/druglist/2020/OR/6tier.	Preferred generic drugs & generic drugs	0% coinsurance / preferred retail prescription 0% coinsurance / preferred mail order prescription 0% coinsurance / retail prescription 0% coinsurance / mail order prescription		No coverage for prescription drugs not on the Drug List. No coverage for prescription drugs from an out-of-network pharmacy. Deductible does not apply for drugs specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. Limited to a 90-day supply retail, 90-day supply mail order or 30-day supply self-administrable cancer chemotherapy and specialty drugs (including preferred). No charge for FDA-approved women's contraceptives and certain preventive drugs and immunizations at a participating pharmacy. The first fill for designated specialty drugs (including preferred) may be provided at a retail pharmacy, additional refills and any fills for other non-designated specialty drugs (including preferred) must be provided at a specialty pharmacy.
	Preferred brand drugs	0% coinsurance / retail prescription 0% coinsurance / mail order prescription		
	Brand drugs	0% coinsurance / retail prescription 0% coinsurance / mail order prescription		
	Preferred specialty drugs & specialty drugs	0% coinsurance / preferred retail prescription 0% coinsurance / retail prescription		

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)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Emergency medical transportation	0% coinsurance	0% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Urgent care	0% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
If you are pregnant	Office visits	0% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	

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 need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	None
	Rehabilitation services	0% coinsurance	50% coinsurance	Limited to 30 inpatient days (up to 60 days for head or spinal cord injury) and 30 outpatient visits each for rehabilitation and habilitation services / year. Includes physical therapy, speech therapy, and occupational therapy. Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
	Habilitation services	0% coinsurance	50% coinsurance	
	Skilled nursing care	0% coinsurance	50% coinsurance	Limited to 60 inpatient days / year.
	Durable medical equipment	0% coinsurance	50% coinsurance	Limited to 1 synthetic wig / year and 1 pair of glasses or contacts / year due to severe medical or surgical problem other than refractive procedures.
	Hospice services	0% coinsurance	50% coinsurance	Limited to 30 inpatient or outpatient respite days / lifetime (limited to a maximum of 5 consecutive respite days at a time).
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance, deductible does not apply	Limited to 1 routine examination / year for individuals under age 19. Coinsurance for out-of-network services does not apply to the out-of-pocket limit.
	Children's glasses	No charge	50% coinsurance, deductible does not apply	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. Coinsurance for out-of-network services does not apply to the out-of-pocket limit.
	Children's dental check-up	No charge	No charge	Limited to 2 cleanings and 2 preventive oral examinations / year for individuals under age 19. Additional coverage is provided for basic and major pediatric dental services.

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
- Cosmetic surgery, except for certain situations
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care, including vision hardware (Adult)
- Routine foot care, except for diabetic patients
- 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.)

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 x61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 367-2116. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (888) 367-2116 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling (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; or by E-mail at: DFR.InsuranceHelp@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 (888) 367-2116.

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	**$4,250**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,250
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,310**

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

The plan's overall deductible	**$4,250**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,250
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$255
The total Joe would pay is	**$4,505**

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

The plan's overall deductible	**$4,250**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

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

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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

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

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

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

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

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

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

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

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. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions, call Regence at 1 (888) 367-2116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 367-2116 to request a copy.

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

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 provider's office or clinic	Routine vision examination and vision hardware	No charge up to the VSP doctor limit	No charge up to the out-of-network provider limit	Limited to individuals age 19 or older. Routine examination limited to 1 every calendar year and limited to $45 for an out-of-network provider. Frame or elective contact lenses* limited to $150 from a VSP doctor / every calendar year; frame allowance limited to $80 from a VSP approved wholesale/retail vendor; and $70 from an out-of-network provider / every calendar year. 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. Lenses from an out-of-network provider limited to: $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). *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.
	Contact lens evaluation and fitting examination	$60 copay	No charge up to the out-of-network provider limit*	Limited to individuals age 19 or older. Limited to 1 contact lens evaluation and fitting examination every calendar year. *Coverage from an out-of-network provider is included in the elective contact lens or necessary contact lens allowance described above.

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 testing	No charge	No charge up to the out-of-network provider limit	Limited to individuals age 19 or older. Supplemental testing allowance limited to $125 for out-of-network providers. Supplemental testing and supplemental aids limited to a combined maximum of $1,000 once every 2 calendar years.
	Low vision supplemental aids	25% coinsurance	25% coinsurance	

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.)

- Corrective vision treatment of an experimental nature
- Cosmetic services and supplies
- Fees, taxes, interest
- Medical or surgical treatment of the eyes
- Non-direct patient care
- Orthoptics or vision training
- Personal comfort items
- Plano lenses
- Two pair of glasses in lieu of bifocals

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
Medicare 1-844-872-6065
Commercial 1-844-299-3041
(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

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.

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: TTY: 1-800-428-4833).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (ATS : 1-800-428-4833)

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。Medicare: 1-844-872-6065; Commercial: 1-844-299-3041（TTY: 1-800-428-4833）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833.)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)¶

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (መስማት ለተሳናቸው:- 1-800-428-4833)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: 1-800-428-4833)

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (टिटिवाइ: 1-800-428-4833

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

MAANDO: To a waawi [Adamawa], e woodi balloojima to ekkitaaki wolde caahu. Noddu Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

Language assistance

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-428-4833)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم Medicare: 1-844-872-6065;
Commercial: 1-844-299-3041
(رقم هاتف الصم والبكم TTY: 1-800-428-4833)

BRONZE 5000 HSA + VISION

2020 BENEFIT ENROLLMENT GUIDE

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/go/2020/booklet/OR/BronzeHSA5000 or call 1 (888) 367-2116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 367-2116 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $5,000 individual (single coverage) / $10,000 family per calendar year. Out-of-network: $10,000 individual (single coverage) / $20,000 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $6,900 individual (single coverage) / $13,800 family* per calendar year. Out-of-network: $15,000 individual (single coverage) / $30,000 family per calendar year. *A member on family coverage will not have his or her in-network out-of-pocket limit exceed $8,150.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, coinsurance for out-of-network pediatric vision services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See regence.com/go/OR/Preferred or call 1 (888) 367-2116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay / office visit $20 copay / office visit at a retail clinic; 50% coinsurance for all other services	50% coinsurance	Copayment applies to each in-network office visit only. All other services that are not billed as an office visit are covered at the coinsurance specified. Coverage for acupuncture and chiropractic spinal manipulations is subject to $40 copayment / visit. Limited to $1,000 / year for all acupuncture and chiropractic spinal manipulation services combined.
	Specialist visit	$60 copay / office visit; 50% coinsurance for all other services	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at regence.com/go/druglist/2020/OR/6tier.	Preferred generic drugs & generic drugs	50% coinsurance* / preferred retail prescription 45% coinsurance / preferred mail order prescription 50% coinsurance* / retail prescription 45% coinsurance / mail order prescription		No coverage for prescription drugs not on the Drug List. No coverage for prescription drugs from an out-of-network pharmacy. Deductible does not apply for drugs specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. Limited to a 90-day supply retail, 90-day supply mail order or 30-day supply self-administrable cancer chemotherapy and specialty drugs (including preferred). No charge for FDA-approved women's contraceptives and certain preventive drugs and immunizations at a participating pharmacy. The first fill for designated specialty drugs (including preferred) may be provided at a retail pharmacy, additional refills and any fills for other non-designated specialty drugs (including preferred) must be provided at a specialty pharmacy. Coverage for self-administrable cancer chemotherapy drugs is 50% coinsurance. *Discount of 5% off coinsurance when filled at a preferred retail pharmacy.
	Preferred brand drugs	50% coinsurance* / retail prescription 45% coinsurance / mail order prescription		
	Brand drugs	50% coinsurance* / retail prescription 45% coinsurance / mail order prescription		
	Preferred specialty drugs & specialty drugs	20% coinsurance / preferred retail prescription 50% coinsurance / retail prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance for ambulatory surgery center; 50% coinsurance for all other facilities	50% coinsurance	None
	Physician/surgeon fees	40% coinsurance for ambulatory surgery center physicians; 50% coinsurance for all other physicians	50% coinsurance	None

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 need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Emergency medical transportation	50% coinsurance	50% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Urgent care	$60 copay / office visit; 50% coinsurance for all other services	50% coinsurance	Copayment applies to each in-network office visit only. All other services that are not billed as an office visit are covered at the coinsurance specified.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay / office visit; 50% coinsurance for all other services	50% coinsurance	Copayment applies to each in-network outpatient office/psychotherapy visit only. All other outpatient services are covered at the coinsurance specified.
	Inpatient services	50% coinsurance	50% coinsurance	Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
If you are pregnant	Office visits	50% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	50% coinsurance	50% coinsurance	

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 need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	None
	Rehabilitation services	$40 copay / outpatient visit; 50% coinsurance / inpatient services	50% coinsurance	Limited to 30 inpatient days (up to 60 days for head or spinal cord injury) and 30 outpatient visits each for rehabilitation and habilitation services / year. Includes physical therapy, speech therapy, and occupational therapy. Copayment applies to each in-network outpatient visit only. Inpatient services are covered at the coinsurance specified. Limited to $3,000 / day for inpatient non-emergency admission in non-participating facilities.
	Habilitation services	$40 copay / outpatient visit; 50% coinsurance / inpatient services	50% coinsurance	
	Skilled nursing care	50% coinsurance	50% coinsurance	Limited to 60 inpatient days / year.
	Durable medical equipment	50% coinsurance	50% coinsurance	Limited to 1 synthetic wig / year and 1 pair of glasses or contacts / year due to severe medical or surgical problem other than refractive procedures.
	Hospice services	50% coinsurance	50% coinsurance	Limited to 30 inpatient or outpatient respite days / lifetime (limited to a maximum of 5 consecutive respite days at a time).

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 your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance, deductible does not apply	Limited to 1 routine examination / year for individuals under age 19. Coinsurance for out-of-network services does not apply to the out-of-pocket limit.
	Children's glasses	No charge	50% coinsurance, deductible does not apply	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. Coinsurance for out-of-network services does not apply to the out-of-pocket limit.
	Children's dental check-up	No charge	No charge	Limited to 2 cleanings and 2 preventive oral examinations / year for individuals under age 19. Additional coverage is provided for basic and major pediatric dental services.

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
- Cosmetic surgery, except for certain situations
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care, including vision hardware (Adult)
- Routine foot care, except for diabetic patients
- 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.)

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 x61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 367-2116. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (888) 367-2116 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling (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; or by E-mail at: DFR.InsuranceHelp@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 (888) 367-2116.

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	**$5,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,960**

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

The plan's overall deductible	**$5,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$280
Coinsurance	$722
What isn't covered	
Limits or exclusions	$255
The total Joe would pay is	**$6,257**

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

The plan's overall deductible	**$5,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,664
Copayments	$261
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

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

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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

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

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

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

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

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

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

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

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. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions, call Regence at 1 (888) 367-2116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 367-2116 to request a copy.

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

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 provider's office or clinic	Routine vision examination and vision hardware	No charge up to the VSP doctor limit	No charge up to the out-of-network provider limit	Limited to individuals age 19 or older. Routine examination limited to 1 every calendar year and limited to $45 for an out-of-network provider. Frame or elective contact lenses* limited to $150 from a VSP doctor / every calendar year; frame allowance limited to $80 from a VSP approved wholesale/retail vendor; and $70 from an out-of-network provider / every calendar year. 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. Lenses from an out-of-network provider limited to: $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). *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.
	Contact lens evaluation and fitting examination	$60 copay	No charge up to the out-of-network provider limit*	Limited to individuals age 19 or older. Limited to 1 contact lens evaluation and fitting examination every calendar year. *Coverage from an out-of-network provider is included in the elective contact lens or necessary contact lens allowance described above.

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 testing	No charge	No charge up to the out-of-network provider limit	Limited to individuals age 19 or older. Supplemental testing allowance limited to $125 for out-of-network providers. Supplemental testing and supplemental aids limited to a combined maximum of $1,000 once every 2 calendar years.
	Low vision supplemental aids	25% coinsurance	25% coinsurance	

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.)

- Corrective vision treatment of an experimental nature
- Cosmetic services and supplies
- Fees, taxes, interest
- Medical or surgical treatment of the eyes
- Non-direct patient care
- Orthoptics or vision training
- Personal comfort items
- Plano lenses
- Two pair of glasses in lieu of bifocals

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
Medicare 1-844-872-6065
Commercial 1-844-299-3041
(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

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.

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: TTY: 1-800-428-4833).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (ATS : 1-800-428-4833)

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。Medicare: 1-844-872-6065; Commercial: 1-844-299-3041（TTY: 1-800-428-4833）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833.)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)¶

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (መስማት ለተሳናቸው:- 1-800-428-4833)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: 1-800-428-4833)

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (टिटिवाइ: 1-800-428-4833

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

MAANDO: To a waawi [Adamawa], e woodi balloojima to ekkitaaki wolde caahu. Noddu Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

Language assistance

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-428-4833)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم Medicare: 1-844-872-6065;
Commercial: 1-844-299-3041
(رقم هاتف الصم والبكم TTY: 1-800-428-4833)