Regence HSA Healthplan 3.0

Preferred

Effective January 1, 2026 through December 31, 2026

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

Cost Share Details		In-Network	Out-of-Network
Annual Medical Deductible	The total deductible You pay per calendar year	$3,500 Individual $7,000 Family	Shared with In-Network
Annual Prescription Deductible	The total deductible You pay per calendar year for prescription medications	Shared with medical	
Annual Out-of-Pocket Maximum	The combined total for Your deductible(s), coinsurance and copays per calendar year	$5,000 Individual $10,000 Family	Shared with In-Network

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, the overall family deductible must be met before the plan begins to pay.

The In-Network Out-of-Pocket Maximum for any Member on Family Coverage is not to exceed $6,850, including the In-Network Deductible. If a Member reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, including the In-Network Deductible, benefits will be paid at 100% of the Allowed Amount for that Member.

Be aware that Your actual costs for Covered Services provided by an Out-of-Network Provider may exceed the Out-of-Pocket Maximum amount. In addition, Out-of-Network Providers and Out-of-Network pharmacies can bill You for the difference between the amount charged and Our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum.

Medical Benefits *(unless stated otherwise, a deductible applies)*		What You Pay	
		In-Network	Out-of-Network
Primary Care Visits (for Illness or Injury)		First 3 Primary Care, Behavioral Health and Virtual Care visits combined, 0% After 3 visits, 20%	40%
Specialist Visits		20%	40%
Urgent Care Visits		20%	40%
Other Professional Services		20%	40%
Preventive Care / Immunizations	Wellness Rewards available	Covered in full	40%
Radiology and Laboratory - Outpatient		20%	40%
Complex Imaging - Outpatient	CT / PET / SPECT scans, MRIs, MRAs, etc.	20%	40%
Acupuncture	30 visits per calendar year	20%	
Ambulance Services	Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment	20%	
Ambulatory Surgical Center		10%	40%
Behavioral Health - Inpatient		20%	40%
Behavioral Health - Outpatient	In addition to this benefit, see Employee Assistance Program (EAP) option	First 3 Primary Care, Behavioral Health and Virtual Care visits combined, 0% After 3 visits, 20% All other outpatient services, 20%	40%
Emergency Room	Facility and professional services	20%	
Hearing Aids, Cochlear Implants and Assistive Listening Devices	Limitations apply Excludes: routine hearing examinations, television caption decoder or cords	20%	40%
Hospital Care	See Ambulatory Surgical Center for cost reduction option	20%	40%

Medical Benefits *(unless stated otherwise, a deductible applies)*		What You Pay	
		In-Network	Out-of-Network
Maternity Care		20%	40%
Neurodevelopmental Therapy	25 visits per calendar year	20%	40%
Newborn Home Visits	Within 6 months of age, at least one visit during first 3 months, with up to 3 more available	Covered in full	Not covered
Rehabilitation Services - Inpatient	30 days per calendar year	20%	40%
Rehabilitation Services - Outpatient	25 visits per calendar year	20%	40%
Skilled Nursing Facility	60 days per calendar year	20%	40%
Spinal Manipulations	30 spinal manipulation visits per calendar year	20%	
Virtual Care - Telehealth	Doctor visits via phone or video chat when not in a healthcare facility (includes Behavioral Health visits)	First 3 Primary Care, Behavioral Health and Virtual Care visits combined, 0% After 3 visits: **Vendor:** 10% **In-Network non-Vendor Provider:** 20%	40%

Prescription Medication Benefits *(unless stated otherwise, a deductible applies)*		What You Pay
Tier 1	90-day supply for retail or home delivery	20% retail prescription / 20% home delivery prescription
Tier 2	90-day supply for retail or home delivery	20% retail prescription / 20% home delivery prescription
Tier 3	90-day supply for retail or home delivery	20% retail prescription / 20% home delivery prescription
Specialty Select	30-day supply for retail	Refer to tiers 1, 2 and 3 above for specialty drugs

Deductible waived on retail or home delivery prescriptions for medications on the Optimum Value Medication List (OVML) located on Our website
Insulin Cost Share Cap: *Retail or home delivery: $35 cap on Member cost share per 30-day supply, deductible waived; $105 cap on Member cost share up to 90-day supply, deductible waived*
20% for each self-administered Cancer Chemotherapy medication
You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and / or coinsurance
More information about prescription drug coverage, including tier specific information, is available at https://regence.com/go/2026/OR/3tierStd

Value-Added Services	
Your Regence coverage includes access to the value-added services detailed here. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS.** For additional information regarding any of these value-added services, visit Our website or contact Customer Service.	
Employee Assistance Program (EAP)	EAP is short-term, confidential counseling with no out-of-pocket expense. (4 mental health counseling visits per issue)
Joint, Spine, and Muscle Program	The Joint, Spine, and Muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles.
Kidney Health Management	If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD).
Mobile APP	Quick access to: ID card, chat with Customer Service, View Claims, Estimate Treatment Cost, Pharmacy pricing.
Nurse Advice	You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care 24 / 7. However, if You are experiencing a medical emergency, immediately call 911 instead.
Pregnancy Program	Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions; the Pregnancy Program can help.
Regence Advantages	Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services.

Value-Added Services	
Regence Empower	Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. Wellness Rewards available.

Provider Networks

Your enrolled network is Preferred. There are several Provider networks in Your state. Please note that these networks are not interchangeable and support different Providers. To find Providers in Your network, please sign into Your account and use Our Provider search tool: https://regence.com/go/OR/Preferred.

Out-of-Area Services

Outside of the service area, Members have In-Network benefits at Blue Cross and / or Blue Shield (Blue Plan) facilities across the country through the BlueCard® Program and worldwide through the Blue Cross Blue Shield Global® Core Program. Any other services will not be covered when processed through any Inter-Plan arrangements. Out-of-Network, You may be balance billed. Call 1-800-810-BLUE (2583) to learn how to get access.

Frequently Asked Questions	
How is my privacy protected?	Regence is committed to the confidentiality and security of Your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of Your personal information. You can view Our full privacy practices online at regence.com.
Is there a cost for "Covered in full"?	No, if Your benefit is covered in full there is no copay or deductible.
What if I need access to specialty care? Do I need a referral?	You can receive care from any In-Network Provider without a referral. For some services, prior authorization may be required.

This benefit summary provides a brief description of Your plan benefits, limitations and / or exclusions under Your plan and is not a guarantee of payment. Once enrolled, You can view Your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND / OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY**. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and Members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and Members.

Customer Service: 1-888-367-2116 - TTY: 711 | 200 SW Market Street 11th Floor, Portland, OR 97201 | regence.com

Regence Choice Vision

Effective January 1, 2026 through December 31, 2026

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Vision Benefits		VSP Network	Out-of-Network
Routine Vision Examination	1 comprehensive routine eye examination per Member per calendar year	$0 copay	Allowance up to $45
Contact Lens Evaluation and Fitting Examination	1 contact lens evaluation and fitting examination per Member per calendar year	$60 copay	See Contact Lenses
Contact Lenses	Elective contact lenses are available once during any calendar year in lieu of all other lenses and frame benefits available. Member will not be eligible for any lenses and / or frames again until the next calendar year.	No charge up to $250 VSP Provider limit	Contact lens allowance up to: Elective contacts, combined with fitting / evaluation services $105 Necessary contacts, including fitting / evaluation services $210
Vision Frames	1 frame per calendar year	No charge up to $250 VSP Provider limit or $135 VSP approved wholesale / retail vendor limit	Allowance up to $70
Vision Lenses	1 pair of standard glass or plastic lenses per calendar year for either: Single vision lenses; lined bifocal (or standard progressive) lenses; lined trifocal lenses; or lenticular lenses.	No charge for VSP doctors	Lens allowance up to: Single vision lenses $30 Lined bifocal or standard progressive lenses $50 Lined trifocal lenses $65 Lenticular lenses $100
VSP LightCare	1 pair of non-prescription sunglasses or blue light filter glasses in lieu of all other lenses and frame benefits available. Member will not be eligible for any lenses and / or frames again until the next calendar year.	No charge up to $250 VSP Provider limit or $135 VSP approved wholesale / retail vendor limit	Allowance up to $70

Additional Discounts

You are entitled to receive a 20% discount toward the purchase of non-covered materials from any VSP Doctor when a complete pair of glasses is dispensed. You are also entitled to receive a 15% discount off of contact lens examination services from any VSP Doctor beyond the covered examination. VSP Doctors may request an additional examination at a discount within 12 months if necessary.

Discount of 15%-20% off or 5% off a promotional offer for laser surgery.

Discounts are applied to the VSP Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye examination. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS VISION PLAN, BUT ARE NOT INSURANCE.** Please refer to Your benefits booklet or Summary Plan Description for complete details.

Limitations

- Discounts do not apply to vision care benefits obtained from Out-of-Network Provider;
- 20% discount applies to complete pairs of glasses only; and
- Discounts do not apply to sundry items, for example, contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

Frequently Asked Questions

Balance billing	Choosing Out-of-Network Providers means Your out-of-pocket expenses will be higher than choosing a VSP Doctor. Also, an Out-of-Network Provider may bill You for balances beyond any Copayment and / or Coinsurance.
How is my privacy protected?	Regence is committed to the confidentiality and security of Your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of Your personal information. You can view Our full privacy practices online at regence.com.

This benefit summary provides a brief description of Your plan benefits, limitations and / or exclusions under Your plan and is not a guarantee of payment. Once enrolled, You can view Your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND / OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY**. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and Members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and Members.

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 less favorably because of race, color, national origin, age, disability, or sex.

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

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

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

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, available 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, D.C. 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, kojį' 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)