Regence

2022 City of Albany Firefighters $300 Ded., with vision Benefit Summary

	Preferred Provider Members Pay	Participating Provider Members Pay	Non-Participating Provider Members Pay
Annual Costs			
Single Deductible	$300		
Family Deductible	$900		
Single Out-of-Pocket Maximum	$1,500		
Family Out-of-Pocket Maximum	$3,000		
Medical Services			
Primary Care Office Visits	$20 copay $10 copay vendor telehealth $20 copay non-vendor telehealth	$35 copay $10 copay vendor telehealth $35 copay non-vendor telehealth	30% coinsurance
Specialist Office Visits	$20 copay for visit, deductible waived	$35 copay for visit, deductible waived	30% coinsurance
Acupuncture and Chiropractic Spinal Manipulations	◆ Coverage for acupuncture and chiropractic spinal manipulations is subject to $25 copayment / visit, deductible does not apply. ◆ Limited to 12 vists/year for each acupuncture and chiropractic spinal manipulations services.		
Preventive Care/ Screening/Immunizations	No charge	No charge	30% coinsurance
Other practitioner office visit	10% coinsurance	30% coinsurance	30% coinsurance
Urgent Care Visit	Covered the same as a visit and other services in this document		
Emergency Room Services	$100 copay, then 10% coinsurance	$100 copay, then 10% coinsurance	$100 copay, then 10% coinsurance
Ambulance Services	10% coinsurance	10% coinsurance	10% coinsurance
Hospital Outpatient Care	10% coinsurance	30% coinsurance	30% coinsurance
Ambulatory Surgical Center	5% coinsurance	30% coinsurance	30% coinsurance
Outpatient Laboratory and Radiology: X-ray, Blood Work, CT/PET Scans, MRIs	No charge for the first $400 / outpatient services Combined Preferred, Participating and Non-Participating Once the limit is met, the following apply after deductible:		
	10% coinsurance	30% coinsurance	30% coinsurance
Mental/Behavioral Health/Substance Use Disorder Outpatient Therapy Services	$20 copay / office visit, deductible waived 10% all other services	$35 copay / office visit, deductible waived 30% all other services	30% coinsurance, deductible waived
Mental/Behavioral Health/Substance Use Disorder Inpatient Services	10% coinsurance	30% coinsurance	30% coinsurance
Home Health Care ◆ Limited to 130 visits/year	10% coinsurance	10% coinsurance	30% coinsurance
Hospital Inpatient Care	10% coinsurance	30% coinsurance	30% coinsurance

Rehabilitation Services ◆ Outpatient: 25 visits per year ◆ Inpatient: 30 days per year	10% coinsurance	30% coinsurance	30% coinsurance
Habilitation Services ◆ Outpatient: 25 visits per year	10% coinsurance	30% coinsurance	30% coinsurance
Skilled Nursing Care ◆ Limited to 60 inpatient days per year	10% coinsurance	30% coinsurance	30% coinsurance
Durable Medical Equipment	10% coinsurance	30% coinsurance	30% coinsurance

Prescription 3-Tier Benefit Summary

Covered Prescription Medication Services

Coverage is limited to a 90-day supply retail or mail order, 30-day for Specialty

Generic	$10 copay retail prescription $30 copay mail order prescription $10 copay / self-administrable cancer chemotherapy prescription
Preferred Brand	$20 copay retail prescription $60 copay mail order prescription $50 copay / self-administrable cancer chemotherapy prescription
Non-Preferred Brand	$40 copay retail prescription $120 copay mail order prescription $100 copay / self-administrable cancer chemotherapy prescription

General Exclusions - *For additional detail please refer to your benefit booklet*

◆ Conditions caused by active participation in a war or insurrection	◆ Orthognathic surgery
◆ Conditions incurred in or aggravated during performances in the uniformed services	◆ Personal comfort items
◆ Cosmetic/reconstructive services and supplies	◆ Physical exercise programs and equipment
◆ Counseling in the absence of illness	◆ Private-duty nursing
◆ Custodial care	◆ Reversals of sterilizations
◆ Dental services	◆ Riot, rebellion and illegal acts
◆ Expenses before coverage begins or after it ends	◆ Routine foot care
◆ Fees, Taxes, Interest	◆ Self-help, self-care, training or instructional programs
◆ Government programs	◆ Services and supplies provided by a member of your family
◆ Hearing care	◆ Services and supplies that are not medically necessary
◆ Infertility	◆ Sexual dysfunction
◆ Investigational services	◆ Third party liability
◆ Motor vehicle coverage and other insurance liability	◆ Travel and transportation expenses
◆ Non-direct patient care	◆ Vision care
◆ Non-duplication of Medicare	◆ Work injury/illness
◆ Obesity or weight reduction/control	

Vision Plan	
Overall deductible	$0
Routine Vision examination and vision hardware ◆ No charge up to the VSP doctor limit ◆ No charge up to the out-of-network provider limit	◆ Routine examination limited to 1 every calendar year and limited to $45 for an out-of-network provider. ◆ Coverage for frames limited to every calendar year. ◆ Frame or elective contact lens* allowance is limited to $200 from VSP doctors. ◆ Frame allowance is limited to $110 for VSP approved wholesale/retail vendor. ◆ 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. ◆ Vision hardware allowance from an out-of-network provider limited to $70 for frames, $30 for single vision lenses, $50 for lined bifocal / standard progressive lenses, $65 for lined trifocal lenses, $100 for lenticular lenses, $200 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 for VSP Doctor ◆ No charge up to the out-of-network provider limit	◆ 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.
Low vision supplemental testing ◆ No charge for VSP Doctor ◆ No charge up to the out-of-network provider limit	◆ 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 for VSP Doctor ◆ 25% coinsurance for out-of-network provider	◆ Supplemental testing and supplemental aids limited to a combined maximum of $1,000 once every 2 calendar years.

Please note: This document is provided for informational purposes only and is intended as a quick reference of Regence Plan Benefits. It is not considered a Summary of Benefits and Coverage (SBC), and should not be regarded as a replacement for the SBC. For cost and further details of the coverage, including exclusions, any reduction or limitations and the terms under which the policy may be continued in force, contact your producer or Regence. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary.

P.O. Box 1271, M/S C7A Portland, OR 97207-1271
Or contact Customer Service: 1(888) 367-2116

www.regence.com

DISCRIMINATION IS AGAINST THE LAW

This Notice has Important Information. Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This notice has important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information, and other information about your application or coverage, in your own language at no cost. Call 888-344-6347. (TTY: 711)

HELP IN OTHER LANGUAGES

The following translations help people who do not read English understand their rights and responsibilities and who to call for help. Including these translations is a federal requirement for all health plans sold on the state or federal marketplaces.

Spanish: Este aviso tiene información importante. Regence cumple con las leyes de derechos civiles federales aplicables y no discrimina sobre la base de raza, color, nacionalidad, edad, discapacidad o sexo. Este aviso tiene información importante sobre su solicitud o cobertura. Busque las fechas importantes en este aviso. Es posible que tenga que tomar alguna acción en un determinado plazo para mantener su cobertura de salud o ayuda con los costos. Usted tiene derecho a obtener esta información y otra información sobre su solicitud o cobertura, en su propio idioma y sin costo. Llame al 888-344-6347. (TTY: 711)

Chinese Traditional: 本通知含有重要資訊。Regence 遵守適用之聯邦政府民權法，不會因種族、膚色、原始出生國籍、年齡、身心障礙或性別的不同而予以差別待遇。本通知含有有關您申請或進行承保的重要資訊。請留意本通知內的重要日期。請在期限之前採取行動，以確保您的醫療保障或協助支付費用。您有權索取使用您語言撰寫的這類資訊，以及有關您申請或承保的相關資訊。請撥打 888-344-6347 索取。（聽障專線：711）

Vietnamese: Thông báo này có Thông tin Quan trọng. Regence tuân thủ luật pháp Liên bang về quyền công dân hiện hành và không phân biệt đối xử theo chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật hoặc giới tính. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Quý vị có quyền lấy thông tin này và thông tin khác về đơn đăng ký hoặc bảo hiểm, bằng ngôn ngữ của mình miễn phí. Gọi số 888-344-6347. (TTY: 711)

Korean: 이 공지 사항에는 중요 정보가 들어 있습니다. Regence은 해당 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 따라 차별하지 않습니다. 이 공지 사항에는 해당 신청서 또는 적용 범위에 관한 중요한 정보가 있습니다. 이 공지 사항의 주요 날짜를 찾아 보십시오. 해당 건강 보험을 그대로 유지하거나 비용을 지원 받으려면 특정 기한까지 조치를 취하셔야 합니다. 귀하는 모국어로 작성된 본 정보나 해당 신청서 또는 보장 범위에 대한 기타 정보를 무료로 받을 수 있는 권리가 있습니다. 888-344-6347로 연락하십시오. (TTY: 711)

Russian: В данном Уведомлении содержится важная информация. Regence несет обязательства по соблюдению применимых норм федерального законодательства о гражданских правах и не допускает дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, статуса инвалидности или пола. В данном уведомлении содержится важная информация о вашем заявлении или страховом покрытии. Обратите внимание на ключевые даты, указанные в данном уведомлении. Возможно, вам нужно предпринять некоторые действия к определенному сроку, чтоб сохранить страховое покрытие или получить помощь с расходами. Вы имеете право получить данную, а также прочую информацию о вашем заявлении или страховом покрытии на родном языке бесплатно. Позвоните по номеру 888-344-6347. (TTY: 711)

Tagalog: Ang Abiso na ito ay may Mahalagang Impormasyon. Ang Regence ay sumusunod sa mga naaangkop na Pederal na batas sa mga karapatang sibil at hindi nagdidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan, o kasarian. Ang abiso na ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o coverage. Hanapin ang mga importanteng petsa sa abiso na ito. Maaaring kailangan mong gumawa ng hakbang hanggang sa mga partikular na takdang araw upang mapanatili mo ang iyong coverage sa kalusugan o tulong sa mga gastusin. May karapatan kang makuha ang impormasyong ito, at iba pang impormasyon tungkol sa iyong aplikasyon o coverage, sa iyong sariling wika nang walang bayad. Tumawag sa 888-344-6347. (TTY: 711)

Ukrainian: Це повідомлення містить важливу інформацію. Regence дотримується застосовного федерального законодавства про громадянські права та не проводить політику дискримінації за расовою приналежністю, кольором шкіри, походженням, віком, інвалідністю та статевою ознакою. Це повідомлення містить важливу інформацію про пов'язану з вами програму або страхове покриття. Зверніть увагу на ключові дати в цьому повідомленні. Щоб зберегти за собою план медичного страхування або право отримувати грошову допомогу, можливо, вам потрібно буде вжити відповідні заходи, для яких установлено певні часові обмеження. Ви маєте право на безкоштовне отримання рідною мовою як цієї інформації, так і будь-якої іншої, пов'язаної з програмою чи страховим покриттям. Телефонуйте за таким номером: 888-344-6347 (телетайп: 711).

Mon-Khmer, Cambodian: សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ ។ Regence
អនុលោមទៅតាមច្បាប់របស់សហព័ន្ធស្តីពីសិទ្ធិពលរដ្ឋ ហើយមិនមានការរើសអើងចំពោះពូជសាសន៍ ពណ៌សម្បុរ
សញ្ជាតិដើម អាយុ ពិការភាព ឬភេទឡើយ ។ សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ស្តីអំពីពាក្យសុំ
ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ។ សូមរកមើលកាលបរិច្ឆេទសំខាន់ៗក្នុងសេចក្តី ជូនដំណឹងនេះ ។
អ្នកអាចត្រូវចាត់វិធានការឲ្យបានត្រឹមកាលបរិច្ឆេទកំណត់ ដើម្បីរក្សាបានន្ទូវការធានារ៉ាប់រងសុខភាព
ឬបានទទួលការជួយចេញការចំណាយស្លៃថែទាំសុខភាពរបស់អ្នក ។ អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ
និងព័ត៌មានដទៃ អំពីពាក្យសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ជាភាសាដែលអ្នកប្រើ
ដោយមិនបាច់បង់ប្រាក់ឡើយ ។ ហៅមកលេខ 888-344-6347 ។ (អ្នកពិបាកស្តាប់ ឬពិបាកនិយាយដែលប្រើ TTY
សូមហៅមកលេខ ៖ 711)

Japanese: このお知らせには大変重要な情報が含まれています。Regence は、適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、身体障害、性別による差別をしません。このお知らせには保険の申請と適用に関する重要な情報が含まれています。このお知らせに記載されている重要な日付にご注意ください。健康保険適用や医療費支援を引き続き受けるためには締切日までに手続きを行う必要があります。あなたにはこのお知らせおよび申請と保険適用に関するその他の情報について、無料かつ母国語で知る権利があります。こちらまでお電話ください: 888-344-6347。(TTY: 711)

Amharic: ይህ ማሳሰቢያ ጠቃሚ መረጃ ይዟል። Regence በሚተገበረው የፌደራል ሲቪል መብቶች ህግጋት በዘር፣ በቀለም፣ በመጡበት ብሄር፣ እድሜ፣ የአካል ጉዳት ወይም ፆታ መድሎ አይደረግም። ማሳሰቢያው ስለ ማመልከቻዎትና ሽፋን ጠቃሚ መረጃ አለው። በዚህ ማሳሳቢያ ላይ ቁልፍ ቀናትን ይፈልጉ። በተወሰኑ የመጨረሻ ቀናት የጤና ሽፋኑ ላይ ወይም የወጪን ድጋፍ እንዲቀጥል አረምጃ መውሰድ ያስፈልጋል። ይህንን መረጃ እንዲሁም በማመልከቻዎት ወይም ሽፋኑ ላይ ሌሎችንም መረጃዎች በራስዎን ቋንቋ ያለምንም ክፍያ የማግኘት መብት አሎት። 888-344-6347 ይደውሉ። (ቲቲዋይ፡- 711)

Cushite/Oromo: Beeksisni kun odeeffannoo barbaachisaa qabatee jira. Regence Ulaagaa seera mirga Siivilii Federaalaa kan guutuu fi sanyii, bifa, lammummaa, umrii, miidhama qaamaa ykn saala irratti hundaa'ee addaan hinqoodne dha. Beeksisni kun iyyannoo ykn haguuggii kara keessan irratti odeeffannoo barbaachisaa qabatee jira. Guyyoota furtuu beeksisa kana keessa jiran ilaalaa. Haguuggii fayyaa ykn gargaarsa keessan eeggachuuf hanga dhuma yeroo ta'eetti tarkanfii ta'e gatii bastanii fudhachuu qabdu. Odeeffannoo kana fi waa'ee iyyannoo ykn haguuggii keessanii kaffaltii tokko malee afaan keessaniin argachuuf mirga qabdu. Bilbilaa 888-344-6347. (TTY: 711)

Arabic:

يحتوي هذا الإخطار على معلومات مهمة. تمتثل Regence إلى قوانين الحقوق المدنية الفيدرالية المعمول بها ولا تمارس التمييز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة أو الجنس. يحتوي هذا الإخطار على معلومات مهمة عن الطلب أو التغطية الخاصة بك. ابحث عن التواريخ الرئيسية في هذا الإخطار. فقد تحتاج إلى اتخاذ إجراء ما قبل بعض المواعيد النهائية للحفاظ على التغطية الصحية الخاصة بك أو تلقي مساعدة بخصوص التكاليف. لديك الحق في الحصول على هذه المعلومات والمعلومات الأخرى المتعلقة بالطلب أو التغطية الخاصة بك بلغتك مجانًا. اتصل بالرقم 888-344-6347. (الكتابة عن بُعد للصم: 711)

Punjabi: ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। Regence ਲਾਗੂ ਫੈਡਰਲ ਨਾਗਰਿਕ ਅਧਿਕਾਰਾਂ ਦੇ ਕਨੂੰਨ ਦੇ ਅਨੁਰੂਪ ਹੈ ਅਤੇ ਜਾਤਿ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਪਾਹਿਜਤਾ, ਜਾਂ ਲਿੰਗ ਦੇ ਅਧਾਰ 'ਤੇ ਭੇਦਭਾਵ ਨਹੀਂ ਕਰਦਾ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਤੁਹਾਡੇ ਬੇਨਤੀ-ਪੱਤਰ ਅਤੇ ਸੁਰੱਖਿਆ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮੁੱਖ ਮਿਤੀਆਂ ਵੇਖੋ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਸਿਹਤ ਸੁਰੱਖਿਆ ਰੱਖਣ ਜਾਂ ਲਾਗਤਾਂ ਨਾਲ ਮਦਦ ਕਰਨ ਲਈ ਨਿਯਤ ਮਿਆਦ ਸੀਮਾਵਾਂ ਦੁਆਰਾ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ। ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ, ਅਤੇ ਆਪਣੇ ਬੇਨਤੀ ਪੱਤਰ ਜਾਂ ਸੁਰੱਖਿਆ ਬਾਰੇ ਹੋਰ ਜਾਣਕਾਰੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। 888-344-6347 'ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

German: Diese Mitteilung enthält wichtige Informationen. Regence hält die Grundrechte der USA ein und es finden keine Diskriminierungen aufgrund von Rasse, Hautfarbe, nationaler Herkunft, Alter, Behinderung oder Geschlecht statt. Diese Mitteilung enthält wichtige Informationen über Ihren Antrag oder die entsprechende Versicherungsdeckung. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Sie haben das Recht, diese Informationen und andere Informationen über Ihren Antrag oder Ihren Versicherungsschutz kostenlos in Ihrer Sprache zu erhalten. Rufen Sie folgende Nummer an 888-344-6347. (Fernschreiber: 711)

Laotian: ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສໍາຄັນ. Regence ສອດຄ່ອງກັບກົດໝາຍ ວ່າດ້ວຍ ສິດທິພົນລະເມືອງຂອງຣັຖບານກາງ ທີ່ກ່ຽວຂ້ອງ ແລະ ບໍ່ມີການຈໍາແນກ ເຊື້ອຊາດ, ສີຜິວ, ຊາດກໍາເນີດ, ອາຍຸ, ຄວາມເປັນຄົນພິການ ຫຼື ເພດ. ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການນໍາໃຊ້ຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງ. ຊອກຫາວັນທີທີ່ສໍາຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງການດໍາເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ ເພື່ອ ໃຫ້ສືບຕໍ່ໄດ້ຮັບການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ທ່ານມີສິດເອົາຂໍ້ມູນນີ້ ແລະ ຂໍ້ມູນອື່ນ ກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕິດຕໍ່ 888-344-6347. (TTY: 711)