Regence High Deductible Health Plan 1 w/HSA

Benefits Summary
Effective January 1, 2021

cis benefits
www.cisbenefits.org

These medical plans are insured by CIS, but administered by Regence BlueCross BlueShield (BCBS) of Oregon. This means that CIS, not Regence BCBS, pays for your covered medical services and supplies.

HDHP-1 w/HSA	
Deductible Per Calendar Year	$1,500 Individual $3,000 Family
Out-of-Pocket Maximum Per Calendar Year **Category 1, 2, & 3** – Preferred, Participating, Non-Preferred Providers (includes deductible, medical copays and prescription copays*)	$2,300 Individual $5,050 Family
*__Important Note:__ The family out-of-pocket maximum for a calendar year is satisfied when two or more family members' deductible and coinsurance for covered services for that calendar year total and meet the family's out-of-pocket maximum amount.	

Medical Services	**Member Pays** **Category 1 - Preferred** **Category 2 - Participating**	**Member Pays** **Category 3 - Non-Preferred**
Preventive Care Services		
Routine well-baby care, physical examinations, health screenings, and immunizations *(for a list of covered services, visit our website regence.com, hover over "Member dashboard" at the top, select Preventive Care from the drop down)*	0% for Category 1 & 2 (*deductible waived*) 40% for Category 3 (*deductible applies*)	
Professional Services	**After Deductible – Member Pays**	
Office visits for illness or injury, mental/behavioral health or substance use disorder *(primary care, specialist, naturopath or urgent/immediate care center)*	20%	40%
Outpatient laboratory, radiology, and diagnostic procedures	20%	40%
Maternity care	20%	40%
Therapeutic injections including allergy shots	20%	40%
Hospital/Facility Services	**After Deductible – Member Pays**	
Ambulatory Surgical Center	10% *(20% for all other facilities)*	40%
Emergency room care *(including professional charges)*	20%	
Inpatient/outpatient surgery and surgeon fees	20%	40%
Inpatient mental/behavioral health & substance use disorder	20%	40%
Skilled Nursing Facility – *120 inpatient days per year*	20%	40%
Other Services	**After Deductible – Member Pays**	
Ambulance	20%	
Rehabilitation Services*: Inpatient: Unlimited / Outpatient: 77 visits per year*	20%	40%
Hearing Aids- *applies to children 18 years or younger or children 19 to 25 enrolled in an accredited education institution*	20%	40%
Home health care - *180 visits per year*	20%	40%
Hospice – *14 respite days/lifetime*	0%	
Durable Medical Equipment	20%	40%
Weight Management/Nutritional Counseling and Bariatric Surgery: - Weight management and nutritional counseling visits *Four visits per plan year per member*	0% *(deductible waived)*	
- Bariatric surgery may be covered to treat morbid obesity (participant must meet participation requirements) *Limited to one surgery per claimant lifetime*	$1,000 copay then 20% after deductible *(does not accumulate towards the out-of-pocket maximum)*	$1,000 copay then 40% after deductible *(does not accumulate towards the out-of-pocket maximum)*

Prescription Medication Benefit *If you need drugs to treat your illness or condition, your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182.* *Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.*	**At the Pharmacy (30-day supply)** **Member Pays**	**Mail Order and Retail Smart90 Programs (90-day supply)** **Member Pays**
Individual deductible per calendar year	Shared with Medical Services	
Out-of-pocket maximum each calendar year	Shared with Medical Services	
Generic drugs	20% Retail/Mail Order Prescription	
Preferred brand drugs		
Non-Preferred brand drugs		
Specialty Drugs	Refer to generic, preferred brand and non-preferred brand drugs above, for specialty drugs or self-administrable cancer chemotherapy drug coverage.	
Limitations and Exceptions	***Out-of-pocket limit*** *$3,300 / claimant / year. Coverage is limited to 30-day supply retail or 90-day supply mail order. Long-term medication fills at participating retail pharmacies may be filled for up to a 90-day supply. Visit Express Scripts' website for details. Specialty drug coverage is limited to a 30-day supply.* *Specialty medication filled at a retail pharmacy is subject to 100% copay/coinsurance, and this amount does not accumulate towards the out-of-pocket maximum.* *Certain preventive items and services as defined by the Affordable Care Act are covered at zero-dollar cost share.* ***Deductible*** *waived for generic and preferred brand drugs designated as preventive for treatment of chronic diseases that are on the Preventive Medications List. You are responsible for the difference in cost between a dispensed brand–name drug and the equivalent generic drug, in addition to the* ***copayment*** *and/or* ***coinsurance****, unless your* ***provider*** *specifies "dispense as written."*	

Other services provided by Regence BlueCross BlueShield	**Contact Information**
MDLIVE (Telehealth) - With MDLIVE's telehealth service, you can see a doctor or therapist from home, work or on the go, 24/7/365. Board-certified doctors visit with you by phone or secure video to treat non-emergency medical conditions. They can diagnose symptoms, prescribe medication, and send prescriptions to your pharmacy.	To learn more call 1 (888) 725-3097 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Telehealth.
Chronic Condition Coaching supports and educates members with chronic conditions including hypertension, diabetes, COPD, CAD, CHF, asthma and obesity.	To learn more, please call 1 (866) 865-6725.
BeyondWell - A comprehensive well-being solution for members that integrates wellness activities, goals, rewards and challenges into a single location for a holistic wellness offering.	To learn more, please call 1 (866) 865-6725 or sign on to the CIS Health Manager at www.regence.com and click on BeyondWell.
Case Management - Supports and educates members with serious illnesses or injuries.	To learn more, please call 1 (866) 543-5765 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Case Management.
BabyWise (*Childbirth to Newborn resources*).	To learn more, call 1 (888) 569-2229 or sign on to the CIS Health Manager at www.regence.com and hover on "Programs & Resources", then click on Maternity.
BlueCard Program (Out of Area Services) – access hospital and physicians when outside the four-state area Regence services (Oregon, Idaho, Utah and Washington) as well as receive care in 200 countries around the world.	Find a provider near you at www.regence.com or call 1 (800) 810-BLUE (2583).

Regence

Please note: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. For a detailed description of your plan benefits, visit www.regence.com on or after January 1, 2021. You must set up an account to review your specific plan booklet.

Regence Vision Plan 3 (24/24/24)

Benefits Summary

Effective January 1, 2021

Keep your eyes healthy with Regence Vision Plan 3, administered by the Vision Service Plan Insurance Company (VSP).

cis benefits
www.cisbenefits.org

Benefit	Description	Copay
Your coverage with a VSP Provider		
WellVision Examination®	• Focuses on your eye health and overall wellness • Every calendar year – Children under 19 • Every other calendar year – All members 19 and over	$0
Prescription Glasses		
Frame	• $120 allowance for a wide selection of frames ($65 allowance at Costco, Walmart, Sam's Club) • 20% savings on the amount over your allowance • Every other calendar year	$0
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Lenticular Lenses • Standard, premium, and custom progressive lenses • Polycarbonate lenses covered for dependent children • Every calendar year – Children under 19 • Every other calendar yeas – All members 19 and over	$0 $0 $50 $0
Lens Enhancements	• Average savings of 20-25% on lens enhancements	
Contacts (instead of glasses)	• $166 allowance for contact lenses (including the fitting examination and evaluation) • 15% savings on a contact lens exam • Every other calendar year – Adults • Every calendar year - Children	$0
Safety Glasses (Employee-only Coverage)*		
Frame	• $65 frame allowance for safety frames • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection • Every other calendar year	$0 for frame and lenses
Lenses	• Prescription single vision, lined bifocal, and lined trifocal lenses • Certified according to thes American National Standards Institute (ANSI) guidelines for impact protection • Every calendar year	$0 combined with frames
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your routine examination. Or get 20% off from any VSP provider within 12 months of your last routine examination. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Out-of-Network Providers

If you plan to see a provider other than a VSP doctor, visit regence.com for details. VSP guarantees coverage from VSP doctors only.

Exam……up to $45	Lenticular Lenses……up to $100
Single Vision Lenses……up to $30	Frame ……..……...up to $70
Lined Bifocal Lenses……up to $50	Elective Contacts……...up to $105
Lined Trifocal Lenses……up to $65	Necessary Contacts ……...up to $210

Submit claims for out-of-network providers to: VSP OA Claims; PO Box 385018, Birmingham, AL 35238-5018

Using your Benefits

- **Register at regence.com** Once your plan is effective, review your benefit information.
- **Find any eye care provider who's right for you.** The decision is yours to make—with the largest national network of private-practice doctors, it's easy to find the in-network doctor who's right for you. To find a VSP doctor, visit vsp.com or call 844.299.3041.
- At your appointment, tell them you have VSP and show them your Regence member ID card. Use your member ID and member suffix (e.g. ABC123456789-00).
- The VSP Choice network offers more than 81,000 provider points of access across the country, including both community-based providers as well as the most popular retail chains*, such as Costco®, Walmart®, Sam's Club®, ShopKo®, Visionworks® and any out-of-network provider (lower reimbursement rates).
    - Please note, participation in the VSP network is voluntary; therefore, not all doctors at a retail location may be in the VSP network.

Personalized Care

A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefits, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

- From classic styles to the latest designer frames, you'll find hundreds of options for you and your family.
- Prefer to shop online? Check out all of the brands at **eyeconic.com**, VSP's preferred online eyewear store.

Your vision plan is issued by Regence BlueCross BlueShield of Oregon and insured by CIS but administered by VSP. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered vision services and supplies.

* *Lens enhancements are not covered, but members will receive a 20-25% discount if purchasing an enhancement*

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1 (888) 370-6159. 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) 370-6159 to request a copy. **Please Note:** Your medical plan is issued by Regence BlueCross BlueShield of Oregon and insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 individual (single coverage) / $3,000 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?	$2,300 individual (single coverage) / $5,050 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, 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 https://regence.com/go/OR/Preferred or call 1 (888) 370-6159 for a list of network providers.	You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a nonparticipating 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 a nonparticipating 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
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	40% coinsurance	Coverage includes primary care visits at a retail clinic. Coverage for alternative care (acupuncture and chiropractic spinal manipulations) is subject to 20% coinsurance for preferred and participating providers and 40% coinsurance for nonparticipating providers. Limited to $1,000 / year for all alternative care services combined.
	Specialist visit	20% coinsurance	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	Coinsurance and deductible waived for childhood immunizations from nonparticipating providers. 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)	20% coinsurance	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs	20% coinsurance / retail and mail order prescription			Out-of-pocket limit $2,300 / claimant / year. Deductible does not apply for preferred brand insulin and drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List. 30-day supply / retail prescription 90-day supply / mail order prescription Some prescriptions may be filled for a 90-day supply at participating pharmacies only. Visit Express Scripts website for details. 30-day supply / specialty drug retail prescription
	Preferred brand drugs	20% coinsurance / retail and mail order prescription			
	Brand drugs	20% coinsurance / retail and mail order prescription			
	Specialty drugs	Refer to generic, preferred brand and brand drugs above, for specialty prescription or self-administrable cancer chemotherapy prescription coverage.			

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
Your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.					Specialty medication filled at a retail pharmacy is subject to 100% copayment / coinsurance, and this amount does not accumulate towards the out-of-pocket limit. Certain preventive items and services as defined by the Affordable Care Act are covered at zero dollar cost share. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment and/or coinsurance, unless your provider specifies "dispense as written."
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance for ambulatory surgery center physicians; 20% coinsurance for all other physicians	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.			None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	130 visits / year
	Rehabilitation services	20% coinsurance	20% coinsurance	40% coinsurance	77 outpatient visits / year for all rehabilitation and habilitation services
	Habilitation services	20% coinsurance	20% coinsurance	40% coinsurance	Includes physical therapy, occupational therapy, speech therapy and neurodevelopmental therapy services. Neurodevelopmental therapy limited to individuals under age 18.
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	120 inpatient days / year
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	40% coinsurance	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care, spinal manipulations only
- Hearing aids for individuals up to age 19, or individuals age 19 years of age up to age 26 and enrolled in a secondary school or an accredited educational institution
- 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 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 370-6159. 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) 370-6159 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 1 (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/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFRInsuranceHelp@oregon.gov.

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

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

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

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1 (888) 370-6159.

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,361**

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$731
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$2,409**

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$260
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,760**

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

The Summary of Benefits and Coverage (SBC) document will help you choose a vision plan. The SBC shows you how you and the plan would share the cost for covered vision care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions call Regence at 1 (888) 370-6159. 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) 370-6159 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Vision Event chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	See the Common Vision Event chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	See the Common Vision Event 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 https://regence.com/go/OR/VSPNetwork or call 1 (844) 299-3041 for a list of VSP doctors.	This plan uses a vision provider network (Vision Service Plan). You will pay less if you use a vision provider in the plan's network. You will pay the most if you use an out-of-network vision provider, and you might receive a bill from a vision 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a vision care provider's office or clinic	Routine vision examination and vision hardware	$50 copay for progressive lenses, all other services no charge up to the VSP doctor limit	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 routine eye examination / calendar year Routine eye examination limited to $45 for out-of-network providers. 1 pair of frames / 2 calendar years Frames limited to $120 for VSP doctors. Frames limited to $65 for VSP approved wholesale/retail vendors. Frames limited to $70 for out-of-network providers. 1 pair of glass, plastic or polycarbonate* single vision lenses / calendar year for either: Single vision lenses; Lined bifocal (or standard progressive) lenses; Lined trifocal lenses; Lenticular lenses; or Contact lenses**. Elective contact lenses** limited up to $166 for VSP doctors. Necessary contact lenses** limited to a 2 calendar year supply for VSP doctors. Lenses from out-of-network providers limited to: $30 for single vision lenses $50 for lined bifocal or standard progressive lenses $65 for lined trifocal lenses $100 for lenticular lenses $105 for elective contact lenses** (including fitting/evaluation services) $210 for necessary contact lenses** (including

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				fitting/evaluation services) *Polycarbonate lenses limited to individuals through age 18. **Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any other types of lenses until the next calendar year and frames for the next 2 calendar years.
	Contact lens evaluation and fitting examination	No charge	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 contact lens evaluation and fitting examination / calendar year Elective contact lens evaluation and fitting examination (including elective contacts lenses) limited to $105 for out-of-network providers. Necessary contact lens evaluation and fitting examination (including necessary contacts lenses) limited to $210 for out-of-network providers.
	Low vision supplemental examinations (testing)	No charge	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. $1,000 low vision maximum / 2 calendar years 2 supplemental examinations / 2 calendar years Supplemental examinations limited to $125 for out-of-network providers.
	Low vision supplemental care aids	25% coinsurance	25% coinsurance	
	Prescription safety glasses	No charge	Not covered	Coverage is for employees only 1 pair of prescription safety lenses / 2 calendar years 1 safety frame / 2 calendar years, limited to $65

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 and interest • Medical or surgical treatment of the eyes • Non-direct patient care	• Orthoptics or vision training • Plano lenses • Two pair of glasses in lieu of bifocals

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.

For VSP vision services, contact: **VSP**
1-844-299-3041 (TTY: 1-800-428-4833)

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.

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, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

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

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

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា 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)

Welcome to Express Scripts

CIS and Express Scripts want you to know that Express Scripts manages your prescription plan. We care about your health and work to make medications safer and more affordable. We encourage you to take advantage of the services and resources available to help you and your dependents manage your pharmacy benefit. We look forward to serving you soon!

Why pay more? Make the move to a 3-month supply.

Under your prescription plan, you have the option to order 3-month supplies of long-term medications from certain participating retail pharmacies or through home delivery from Express Scripts Pharmacy®. [1]

To start ordering a 3-month supply from Express Scripts Pharmacy, register or log in at **express-scripts.com**. (Standard shipping is free with home delivery.[2])

To find a retail pharmacy that participates in 3-month supplies, log in at **express-scripts.com** and choose Find a Pharmacy from the menu under Prescriptions. The pharmacy can tell you how to transfer your prescription or start a new one. Search results will indicate whether a pharmacy is eligible to dispense up to a 3-month supply.

According to your plan, you can keep filling one month at a time but you could miss out on convenience and savings.

[1]Long-term medications are taken for an ongoing condition, such as high blood pressure, high cholesterol and asthma.
[2]Cost of standard shipping is included as part of your prescription plan.

Accredo, Your Specialty Pharmacy

Accredo is the Express Scripts specialty pharmacy. A specialty pharmacy provides medication and therapy for patients with serious, chronic conditions like cancer and hepatitis C. Accredo offers teams of pharmacists, nurses and clinicians who are specially trained on your condition. This level of individualized, focused care gives you the most comprehensive, compassionate and customized care available.

Accredo offers many patient support services, including:

- Personal care and health advocacy assistance from patient care coordinators
- Coordination of financial assistance (availability varies by plan)
- Guidance for patients and caregivers for taking specialty medications most effectively
- All necessary ancillary supplies such as syringes and sharps containers

Specialty medications must be filled through Accredo to receive coverage. Included with these materials is a list of specialty drugs. To learn more about Accredo, please visit **accredo.com.**

CIS has partnered with SaveonSP to provide a specialty pharmacy copayment assistance program. If you attempt to fill a specialty prescription that falls under this program, an Accredo representative will assist you with enrollment in the program by transferring you to SaveonSP. More information about this program can be found in your Regence Plan Booklet.

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EXPRESS SCRIPTS®

Network Retail Pharmacies

Network pharmacies are retail pharmacies that are preferred by your prescription plan. Use them for prescriptions you need on a short-term basis, like an antibiotic to treat an infection. When you go to an in-network pharmacy for up to a 30-day supply of medication, you'll typically pay less than at a retail pharmacy that's out of your network.

To find an in-network pharmacy near you, go to **express-scripts.com/CIS4** and select Locate a Pharmacy. Search results will indicate whether a pharmacy is eligible to dispense up to a 3-month supply. You may also log in at **express-scripts.com** and choose **Find a Pharmacy** from the menu under **Prescriptions** or call Express Scripts at 800.496.4182.

If you're new to Regence BCBS coverage, be sure to show your new Express Scripts ID card at the pharmacy. You can also access your ID card by downloading the Express Scripts® mobile app. If you don't show your ID card and instead choose to pay the entire cost of the medication, you must submit a claim form to Express Scripts for reimbursement. You'll be reimbursed based on the covered medication's contracted rate minus the appropriate copayment. This amount will be lower than the amount you paid out of pocket at the retail pharmacy.

If you need to transfer your prescription from an out-of-network pharmacy to an in-network pharmacy, just choose one of the following:

- Bring your prescription vial or container to an in-network pharmacy, and the pharmacist will transfer it.
- Call a pharmacy in your network, and ask the pharmacist to transfer your medication.
- Ask your doctor to send your prescription in to an in-network pharmacy using e-prescribing.

Manage Your Prescription

One of the great things about being an Express Scripts member is that you can manage your medication easily on your laptop, tablet, desktop or phone. Whether you want to check your order status, look for savings opportunities, look up information about your benefit, get a refill or even find a pharmacy, the Express Scripts website and mobile app can help!

Just register at express-scripts.com or download the mobile app to your mobile device for free by searching your app store for Express Scripts. (Availability and features may vary.)

Formulary

A preferred drug list, also called a formulary, helps keep healthcare costs down for everybody. It's a list of medications that have been reviewed and approved for safety and effectiveness by a panel of doctors and pharmacists. This list is continually reviewed and updated as new medications become available.

Note that certain medications are excluded from your formulary, which means they're not covered. An equally effective and safe alternative may be available. To check pricing and coverage for a medication, visit express-scripts.com/CIS4. Drug classes with excluded medications include Autonomic and Central Nervous System, Cardiovascular and Dermatological.

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EXPRESS SCRIPTS®

Specialty Drug List

Unless otherwise noted, all brand and generic formulations of a product are considered specialty.

ALPHA 1 DEFICIENCY
Aralast NP®
Glassia™
Zemaira®

ANTICOAGULANT
Arixtra®* (fondaparinux sodium)
Fragmin®*
Iprivask®
Lovenox®*(enoxaparin sodium)

ASTHMA & ALLERGY
Dupixent®
Durysta™
Fasenra™
Nucala®
Xolair®

BLOOD CELL DEFICIENCY
Aranesp®
Doptelet®
Epogen®
Fulphila™
Granix™
Leukine®
Mozobil®
Mulpleta®
Neulasta®
Neupogen®
Nivestym™
Nplate®
Procrit®
Promacta®
Retacrit™
Udenyca™
Zarxio™
Ziextenzo®

CANCER
Abraxane®
Adcetris™
Afinitor® (everolimus)
Alecensa®
Alunbrig™
Arranon®
Arzerra®
Avastin®
Belrapzo®
Bendamustine®
Bendeka™
Besponsa®
Bosulif®
Cabometyx™
Cometriq™
Cotellic®
Cyramza™
Dacogen® (decitabine)
Darzalex®
Darzalex Faspro™
Daurismo™
Eligard®
Empliciti™
Enhertu®
Erbitux®
Erivedge™
Erleada™
Farydak®
Firmagon®
Folotyn®
Gazyva™
Gilotrif™
Gleevec® (imatinib)
Halaven™
Herceptin®
Herceptin Hylecta™
Herzuma®
Hycamtin® (capsules)
Hycamtin® (topotecan injection)
Ibrance®
Idhifa®
Imfinzi™
Inlyta®

CANCER (cont'd)
Inrebic®
Intron A®
Iressa®
Istodax® (romidepsin)
Ixempra®
Jakafi™
Jevtana®
Kadcyla™
Kanjinti™
Kepivance®
Kisqali®
Kisqali Femara®
Lartruvo™
Lenvima™
Lonsurf®
Lorbrena®
Lupron Depot®
Lynparza™
Mekinist™
Mvasi™
Nerlynx™
Nexavar®
Ninlaro®
Nubeqa®
Odomzo®
Ogivri™
Ontruzant®
Onureg®
Opdivo®
Pegasys®
Peg-Intron®
Perjeta™
Phesgo™
Piqray®
Polivy™
Pomalyst®
Portrazza™
Proleukin®
Retevmo™
Revlimid®
Rituxan®
Rituxan Hycela®
romidepsin
Rozlytrek™
Rubraca™
Ruxience™
Rydapt®
Sprycel®
Stivarga®
Sutent®
Sylvant™
Tabrecta™
Tafinlar®
Tagrisso™
Talzenna™
Tarceva® (erlotinib)
Targretin® (bexarotene)
Tasigna®
Tecentriq™
Temodar® (temozolomide)
Thalomid®
Torisel® (temsirolimus)
Trazmiera™
Treanda®
Truxima®
Tykerb®
Valchlor™
Valstar®
Vantas®
Vectibix®
Velcade®
Verzenio ™
Vidaza® (azacitidine)
Vitrakvi®
Vizimpro®
Votrient®
Xalkori®
Xeloda®(capecitabine)
Xgeva™
Xtandi®
Yervoy™
Yonsa®
Zaltrap®
Zelboraf™

CANCER (cont'd)
Zirabev™
Zoladex®
Zolinza®
Zometa® (zoledronic acid)
Zydelig®
Zykadia™
Zytiga™ (abiraterone acetate)

CONTRACEPTIVES
Liletta™
Nexplanon®

CYSTIC FIBROSIS
Bethkis®
Cayston®
Kalydeco™
Kitabis Pak™
Orkambi™
Pulmozyme®*
Symdeko™
Tobi® (tobramycin)
Tobi Podhaler™
Trikafta™

ENDOCRINE DISORDERS
Bynfezia Pen™
Crysvita®
Egrifta®
Lupaneta Pack™
Lupron Depot-Ped®
Myalept™
Natpara®
Samsca® (tolvaptan)
Sandostatin® (octreotide acetate)
Sandostatin LAR Depot®
Signifor® LAR
Signifor®
Somatuline Depot®
Somavert®
Supprelin LA®
teriparatide

ENZYME DEFICIENCIES
Aldurazyme®
Carbaglu®
Cerdelga™
Cerezyme®
Elaprase®
Elelyso™
Fabrazyme®
Galafold™
Kanuma™
Kuvan® (sapropterin)
Lumizyme™
Mepsevii™
Naglazyme®
nitisinone
Nityr™
Palynziq™
Ravicti™
Sucraid®
Vimizim™
VPRIV™
Zavesca® (miglustat)

GROWTH DEFICIENCY
Genotropin®
Humatrope®
Increlex®
Macrilen®
Norditropin Flexpro®
Nutropin AQ®
Omnitrope®
Saizen®
Serostim®
Zomacton®
Zorbtive®

HEMOPHILIA
Advate®
Adynovate™
Afstyla®

1. Some products may be dispensed from Accredo and/or Freedom Fertility Pharmacy
2. Xyrem® is distributed through Express Scripts Specialty Distribution Services, Inc.

Disclaimer: Note that additional generic versions of listed medications may be available. Please consult your pharmacist to determine if a generic version of any particular specialty medication is available.

* Your plan may require most specialty medications to be dispensed exclusively by Accredo. Those medications marked by an asterisk (*) may have allowances for one or more retail fills.

accredo®

HEMOPHILIA (cont'd)
Alphanate®
Alphanine SD®
Alprolix™
Benefix®
Corifact®
DDAVP® (desmopressin acetate) (*oral/nasal forms are not specialty)*
Eloctate™
Esperoct®
Feiba NF®
Hemlibra®
Hemofil M®
Humate-P®
Idelvion®
Ixinity®
Jivi®
Koate®
Kogenate FS®
Kovaltry®
Mononine®
Novoeight®
Novoseven RT®
Nuwiq®
Profilnine SD®
Rebinyn®
Recombinate™
RiaSTAP®
Rixubis™
Sevenfact®
Stimate®
Tretten®
Vonvendi™
Wilate®
Xyntha®
Xyntha Solofuse®

HEPATITIS C
Epclusa® (sofosbuvir/velpatasvir)
Harvoni® (ledipasvir/sofosbuvir)
Mavyret™
Ribavirin (Rebetol®, Ribasphere®, Ribapak®, Moderiba™)
Sovaldi®
Viekira Pak®
Vosevi®
Zepatier®

HEREDITARY ANGIOEDEMA
Berinert®
Cinryze®
Firazyr® (icatibant)
Haegarda®
Kalbitor®
Ruconest®
Takhzyro™

HIGH BLOOD CHOLESTEROL
Juxtapid®

HIV
Aptivus®*
Atripla®*
Biktarvy®
Cimduo™
Combivir®* (lamivudine/zidovudine)
Complera®*
Crixivan®*
Delstrigo™*
Descovy®*
Dovato®
Edurant®*
Emtriva®*
Epivir®* (lamivudine)
Epzicom®* (abacavir/lamivudine)
Evotaz™ *
Fuzeon®*
Genvoya®*
Intelence®*
Invirase®*
Isentress®*
Juluca®
Kaletra®* (lopinavir/ritonavir)
Lexiva®* (fosamprenavir)
Norvir®* (ritonavir)
Odefsey®*
Pifeltro™*

HIV (cont'd)
Prezcobix™*
Prezista®*
Rescriptor®*
Retrovir®* (zidovudine)
Reyataz®*(atazanavir)
Rukobia™
Sustiva®*(efavirenz)
Selzentry®*
Stribild®*
SymFi™ (efavirenz/lamivudine/tenofovir disoproxil fumarate)
SymFi Lo™ (efavirenz/lamivudine/tenofovir disoproxil fumarate)
Symtuza™
Temixys™
Tivicay®*
Triumeq®*
Trizivir®*(abacavir/lamivudine/zidovudine)
Trogarzo™
Truvada®*
Tybost®*
Videx®* (didanosine)
Videx EC®*(didanosine DR)
Viracept®*
Viramune®* (nevirapine)
Viramune XR®*(nevirapine ER)
Viread®*(tenofovir disoproxil fumarate)
Vitekta®*
Zerit®* (stavudine)
Ziagen®*(abacavir)

IDIOPATHIC PULMONARY FIBROSIS
Esbriet™
OFEV®

IMMUNE DEFICIENCY
Asceniv™
Bivigam™
Cuvitru™
Cutaquig®
Cytogam®
Gamastan S-D®
Gammagard Liquid®
Gammagard S-D®
Gammaked™
Gammaplex®
Gamunex-C®
Hizentra™
HyQvia™
Panzyga®
Privigen®
Xembify®

INFERTILITY[1]
(oral forms are not specialty)
Bravelle®
Cetrotide®
Chorionic Gonadatropin (brands include Novarel®, Pregnyl®)
Crinone®
Endometrin®
Follistim AQ®
Ganirelix (ganirelix acetate)
Gonal-F®
leuprolide
Menopur®
Ovidrel®
progesterone injection

INFLAMMATORY CONDITIONS
Actemra®
Arcalyst®
Benlysta®
Cimzia®
Cosentyx™
Enbrel®
Entyvio™
Humira®
Ilaris®
Ilumya™
Inflectra™
Kevzara®
Olumiant®
Orencia®
Otezla®
Remicade®
Renflexis™

INFLAMMATORY CONDITIONS (cont'd)
Rinvoq ER™
Siliq™
Simponi™
Simponi Aria®
Skyrizi™
Stelara™
Taltz®
Tremfya™
Xeljanz®
Xeljanz XR®

IRON TOXICITY
Exjade® (deferasirox)
Jadenu™

MISCELLANEOUS DISEASES
Acthar H.P. Gel®
Actimmune®
Apokyn®
Arestin®
Austedo®
Botox®
Botox Cosmetic®
Ceprotin™
Duopa™
Dojolvi™
Dysport®
Enspryng™
Epidiolex®
Gattex®
Givlaari™
Hetlioz™
Inbrija™
Krystexxa®
Makena™ (hydroxyprogesterone caproate)
Myobloc®
Northera™
Nuplazid™
Ocaliva™
Probuphine®
Procysbi™
Sabril® (vigabatrin)
Solesta®
Soliris®
Sublocade™
Tegsedi™
Thyrogen®
Ultomiris™
Vivitrol®
Vyndamax™
Vyndaqel®
Wakix®
Xenazine® (tetrabenazine)
Xeomin®
Xyrem®[2]

MULTIPLE SCLEROSIS
Ampyra® (dalfampridine)
Aubagio®
Avonex®
BAFIERTAM™
Betaseron®
Copaxone® (glatiramer, Glatopa®)
Extavia®
Gilenya®
Lemtrada®
Mavenclad®
Mayzent®
mitoxantrone®
Ocrevus®
Plegridy®
Rebif®
Tecfidera® (dimethyl fumarate)
Tysabri®
Vumerity™
Zeposia®

MUSCULAR DYSTROPHIES
Emflaza™
Spinraza™
Zolgensma®

1. Some products may be dispensed from Accredo and/or Freedom Fertility Pharmacy
2. Xyrem® is distributed through Express Scripts Specialty Distribution Services, Inc.

Disclaimer: Note that additional generic versions of listed medications may be available. Please consult your pharmacist to determine if a generic version of any particular specialty medication is available.

* Your plan may require most specialty medications to be dispensed exclusively by Accredo. Those medications marked by an asterisk (*) may have allowances for one or more retail fills.

OPHTHALMIC CONDITIONS
Beovu®
Eylea®
Iluvien™
Kesimpta Pen®
Lucentis®
Luxturna™
Macugen®
Oxervate™
Ozurdex™
Retisert®
Tepezza™
Visudyne®

OSTEOARTHRITIS
Durolane®
Euflexxa®
Gel-One®
Gelsyn-3™
Hyalgan®
Hymovis®
Monovisc®
Orthovisc®
Supartz FX®
Synvisc®
Synvisc-One®

OSTEOARTHRITIS (cont'd)
Triluron™
Visco-3™

OSTEOPOROSIS
Boniva® (ibandronate) (*oral forms are not specialty)*
Evenity™
Forteo®
Prolia™
Reclast® (zoledronic acid)
Tymlos™

PULMONARY HYPERTENSION
Adcirca® (tadalafil)
Adempas®
Flolan® (epoprostenol)
Flolan Diluent® (epoprostenol diluent)
Letairis® (ambrisentan)
Opsumit®
Orenitram™
Remodulin® (treprostinil)
Remodulin Diluent® (trepostinil diluent)
Revatio® (sildenafil citrate)
Tracleer® (bosentan)
Tyvaso®
Uptravi®
Veletri®
Ventavis®

RESPIRATORY SYNCYTIAL VIRUS
Synagis®

SICKLE CELL DISEASE
Oxbryta™

TRANSPLANT
azathioprine (AZASAN, IMURAN)
Astagraf XL™*
Cellcept®* (mycophenolate mofetil)
Neoral® , Sandimmune®* (cyclosporine, Gengraf®)
Envarsus® XR*
Myfortic®* (mycophenolic acid)
Nulojix®*
Prograf®*(tacrolimus)
Rapamune®*(sirolimus)
Simulect®*
Thymoglobulin®*
Zortress®* (everolimus)

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