

IBEW 125 PGE Health & Welfare Trust

Active PPO Plan

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		Preferred Provider	Participating Provider	Nonparticipating Provider
Annual Medical Deductible	The total deductible You pay per calendar year	\$200 Individual \$400 Family	Shared with Preferred Network	Shared with Preferred Network
Annual Out-of-Pocket Maximum	The combined total for Your deductible(s), coinsurance and copays per calendar year	\$1,200 Individual \$2,400 Family	Shared with Preferred Network	\$3,200 Individual \$6,400 Family

Be aware that Your actual costs for Covered Services provided by a Nonparticipating Network Provider may exceed the Out-of-Pocket Maximum amount. In addition, Nonparticipating Providers 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 <i>(unless stated otherwise, a deductible applies)</i>		What You Pay		
		Preferred Provider	Participating Provider	Nonparticipating Provider
Primary Care Visits (for Illness or Injury)		10%	30%	30%
Specialist Visits		10%	30%	30%
Urgent Care Visits		10%	30%	30%
Other Professional Services		10%	30%	30%
Preventive Care / Immunizations		Covered in full	Covered in full	30%
Radiology and Laboratory - Outpatient		10%	30%	30%
Complex Imaging - Outpatient	CT / PET / SPECT scans, MRIs, MRAs, etc.	10%	30%	30%
Acupuncture	Chiropractic spinal manipulations and acupuncture services from any licensed provider (12 combined visits per calendar year)	20%, deductible waived	20%, deductible waived	20%, deductible waived
Ambulance Services		10%	10%	10%
Ambulatory Surgical Center		10%	30%	30%
Emergency Room (Including Professional Charges)		\$100 copay per visit, then deductible and 10% coinsurance	\$100 copay per visit, then deductible and 10% coinsurance	\$100 copay per visit, then deductible and 10% coinsurance
Hearing Aids & Evaluations	\$4,000 every 4/years	10% deductible waived	30% deductible waived	30% deductible waived
Home Health Care	180 visits per calendar year	10%	30%	30%
Hospice Care	14 days of respite care per lifetime	10%	30%	30%
Behavioral Health - Inpatient		10%	10%	30%
Behavioral Health - Outpatient		10%, deductible waived	10%, deductible waived	30%, deductible waived
Hospital Care		10%	30%	30%
Maternity Care		10%	30%	30%
Neurodevelopmental Therapy	30 visits per calendar year	10%	30%	30%
Nutritional Counseling		10%	30%	30%
Rehabilitation Services - Inpatient	30 days per calendar year	10%	30%	30%
Rehabilitation Services - Outpatient	30 visits per calendar year	10%	30%	30%
Skilled Nursing Facility	100 days per calendar year	10%	30%	30%
Spinal Manipulations - Osteopathic		10%	30%	30%

Prescription Medication Benefits

What You Pay

*1 copay per 30-day supply

Insulin Cost Share Cap: Retail or home delivery: \$35 cap on Claimant cost share per 30-day supply; \$105 cap on Claimant cost share up to 90-day supply
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>

Annual Deductible	The total deductible you pay per calendar year	Not Applicable
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance, and copays per calendar year	\$1,000
Tier 1	90-day supply for retail or mail order	\$5 retail prescription / \$10 mail order prescription / \$10 for each self-administrable Cancer Chemotherapy medication, deductible waived
Tier 2	90-day supply for retail or mail order	\$20 retail prescription / \$40 mail order prescription / \$50 for each self-administrable Cancer Chemotherapy medication, deductible waived
Tier 3	90-day supply for retail or mail order	\$40 retail prescription / \$80 mail order prescription / \$100 for each self-administrable Cancer Chemotherapy medication, deductible waived
Specialty Select	30-day supply for retail (the first fill for specialty drugs may be provided at a retail pharmacy, additional fills must be provided at a specialty pharmacy.)	Refer to tiers 1, 2 and 3 above for specialty drugs

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.

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.
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.

Provider Networks

Your enrolled network is Preferred PPO. 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: regence.com

Out-of-Area Services

Outside of the service area, Claimants have Preferred Provider 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. Outside Preferred Providers, 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 Preferred Providers 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 Claimants under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and Claimants.

Customer Service: 1-866-240-9580 - TTY: 711 | 200 SW Market Street 11th Floor, Portland, OR 97201 | regence.com

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 nínizín: Díí saad bee yánilti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', 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 ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਪਿਆਰ 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 አርዳታ ድርጅቶች በነጻ ሊያገለግሉት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

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

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

ប្រគល់: តើ អ្នក ព្រម ព្រាប ទេ, ការ បំប៉ន ការ ជួយ ចំពោះ ភាសា, ដោយ មិន គិត ថ្លៃ. តេឡេ 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 711 TTY)