Note: Only those benefits or rates that are changing are listed. See your Plan Materials for more information. Any conflict between this Summary of Material Modification and the Plan Document, the Plan Document shall control.

The material modifications for 2016-17 are summarized below.

**Specialist Office Visit - $50**

**CALENDAR YEAR OUT-OF-POCKET MAXIMUM**

**In-Network (Combined Preferred and Participating Providers)**
- Per Claimant: $4,000
- Per Family: $12,000

**Out-of-Network (Nonparticipating Providers)**
- Per Claimant: $8,000
- Per Family: $24,000

**CALENDAR YEAR DEDUCTIBLES**

**In-Network (Combined Preferred and Participating Providers)**
- Per Claimant: $1,500
- Per Family: $4,500

**Out-of-Network (Nonparticipating Providers)**
- Per Claimant: $3,000
- Per Family: $9,000

You do not need to meet any Deductible before receiving benefits for:

- In-Network (Preferred and Participating) Preventive Care and Immunizations;
- In-Network (Preferred) Office Visits (including therapeutic injections);
- In-Network (Preferred) Outpatient Laboratory and Radiology services;
- Alternative Care;
- Emergency Room services;
- In-Network (Preferred and Participating) Adult Immunizations (non-preventive);
- Outpatient Mental Health and Substance Use Disorder Services;
- Vision Benefits (Pediatric Vision and Adult Vision); or
- Telehealth (Preferred and Participating).
Plan Benefits:

Additionally, the Plan covers all United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations. The Plan covers Child Abuse Medical Assessments including those services provided by a Community Assessment Center in conducting a Child Abuse Medical Assessment of a child enrolled on this plan subject to the Deductible, Coinsurance and/or Copayments and Maximum Benefits, if any, as specified in the Medical Benefits of this Summary Plan Description. The Plan covers telehealth (audio and video communication) office visits for primary care services and equivalent behavioral health services between the patient and a preferred or participating Provider.

Prescription Medication Limitations allows 12-month prescription contraceptive dispensing coverage.

Added an exception to the exclusion for hormonal contraceptive patches or self-administered oral hormonal contraceptives prescribed by a pharmacist.

No additional action is necessary on your part. However, if you have any questions about your eligibility for a specific benefit or any other information provided in the Summary of Material Modifications, please contact your Human Resources Department.

Note: To access the benefits booklets contact Regence BCBS of Oregon Customer Service at 866-240-9580.