



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 regence.com or call 1 (888) 367-2116. 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) 367-2116 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$500 individual / \$1,500 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>preventive care</u> and the following services: upfront office/ <u>urgent care</u> visits, upfront outpatient diagnostic test/imaging services, or outpatient mental health and substance use disorder office/psychotherapy visits.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,000 individual / \$9,000 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See regence.com/go/Preferred or call 1 (888) 367-2116 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay the least if you use a <u>provider</u> in the preferred <u>network</u> . You pay more if you use a <u>provider</u> in the participating <u>network</u> . You will pay the most if you use a nonparticipating <u>provider</u> , and you might receive a bill from a nonparticipating <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use a nonparticipating <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> / visit for BDTC* <u>providers</u> , <u>deductible</u> does not apply; \$20 <u>copay</u> / visit for all other providers, <u>deductible</u> does not apply; other services 20% <u>coinsurance</u>	\$35 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 40% <u>coinsurance</u>	40% <u>coinsurance</u>	<p><u>Copayment</u> applies to each <u>preferred</u> or <u>participating</u> upfront office visit only. All other services that are not billed as an office visit are covered at the <u>coinsurance</u> specified, after <u>deductible</u>.</p> <p>Coverage for complementary care (acupuncture and chiropractic spinal manipulations) is subject to \$25 <u>copayment</u> / visit, <u>deductible</u> waived.</p> <p>Limited to 12 visits/ year for all complementary care services combined.</p> <p>*Blue Distinction Total Care (BDTC) <u>providers</u> are <u>preferred providers</u> who have entered into an additional contract with us to take extra measures aimed at improving the quality of care for our members while controlling costs.</p>
	<u>Specialist</u> visit	\$10 <u>copay</u> / visit for BDTC* <u>providers</u> , <u>deductible</u> does not apply; \$20 <u>copay</u> / visit for all other providers, <u>deductible</u> does not apply; other services 20% <u>coinsurance</u>	\$35 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 40% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	No charge	40% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for the first \$400 / year, then 20% <u>coinsurance</u>	No charge for the first \$400 / year, then 40% <u>coinsurance</u>	No charge for the first \$400 / year, then 40% <u>coinsurance</u>	<p>No charge for the first \$400 / year for all upfront outpatient <u>diagnostic tests</u> and imaging combined. Once the limit has been met and for all inpatient services, services are covered at the <u>coinsurance</u> specified, after <u>deductible</u>.</p>
	Imaging (CT/PET scans, MRIs)	No charge for the first \$400 / year, then 20% <u>coinsurance</u>	No charge for the first \$400 / year, then 40% <u>coinsurance</u>	No charge for the first \$400 / year, then 40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at regence.com/go/OR/pdl .	Generic drugs	\$15 <u>copay</u> / retail prescription \$45 <u>copay</u> / mail order prescription \$10 <u>copay</u> / self-administrable cancer chemotherapy prescription			Limited to a 90-day supply retail (1 <u>copayment</u> per 30-day supply), 90-day supply mail order or 30-day supply <u>specialty drugs</u> . No charge for FDA-approved women's contraceptives and certain preventive drugs and immunizations at a participating pharmacy. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the <u>copayment</u> and/or <u>coinsurance</u> . The first fill for <u>specialty drugs</u> may be provided at a retail pharmacy, additional fills must be provided at a specialty pharmacy.
	Preferred brand drugs	\$45 <u>copay</u> / retail prescription \$135 <u>copay</u> / mail order prescription \$50 <u>copay</u> / self-administrable cancer chemotherapy prescription			
	Non-preferred brand drugs	\$100 <u>copay</u> / retail prescription \$300 <u>copay</u> / mail order prescription \$100 <u>copay</u> / self-administrable cancer chemotherapy prescription			
	<u>Specialty drugs</u>	50% up to \$250 maximum <u>copay</u> / retail prescription			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	<u>Copayment</u> applies to the facility charge for each visit (waived if admitted).
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	Covered the same as the If you visit a health care provider's office or clinic or If you have a test above.			None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay</u> / office/psychotherapy visit for BDTC* <u>providers</u> , <u>deductible</u> does not apply; \$20 <u>copay</u> / office/psychotherapy visit for all other <u>providers</u> , <u>deductible</u> does not apply; other services 20% <u>coinsurance</u>	\$20 <u>copay</u> / office/psychotherapy visit, <u>deductible</u> does not apply; other services 20% <u>coinsurance</u>	40% <u>coinsurance</u> , <u>deductible</u> does not apply for office/psychotherapy visits	<u>Copayment</u> applies to each <u>preferred</u> and participating <u>provider</u> outpatient office/psychotherapy visit only. All other outpatient services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . *See page 2 for a description of a BDTC <u>provider</u> .
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 130 visits / year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Inpatient limited to 30 days / year. Outpatient limited to 25 visits / year. Includes physical therapy, occupational therapy and speech therapy services.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Outpatient neurodevelopmental therapy is limited to 25 visits / year. Neurodevelopmental therapy is limited to services for individuals through age 17. Includes physical therapy, occupational therapy and speech therapy services.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 inpatient days / year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
	Hospice services	20% coinsurance	40% coinsurance	40% coinsurance	Respite care is limited to 14 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
	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.)

- Bariatric surgery
- 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, unless required by law

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

- Acupuncture
- Chiropractic care, spinal manipulations only
- Hearing aids for individuals 18 or younger or for enrolled children 19 years of age or older 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 x61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 367-2116. 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) 367-2116 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 (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/gethelp/Pages/file-a-complaint.aspx; or by E-mail at: cp.ins@oregon.gov.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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) 367-2116.

-----*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 \$500
- Specialist copayment \$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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$36
Coinsurance	\$2,263
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,859

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

- The plan's overall deductible \$500
- Specialist copayment \$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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,168
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$255
The total Joe would pay is	\$2,423

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

- The plan's overall deductible \$500
- Specialist copayment \$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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$120
Coinsurance	\$238
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$858