



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 (800) 376-7926. 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 (800) 376-7926 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u>? | \$300 individual / \$900 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 those services listed below as " <u>deductible</u> does not apply" or as "No charge." | 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>? | In- <u>network</u> : \$1,100 individual / \$2,500 family per calendar year. Out-of- <u>network</u> : \$1,900 individual / \$4,100 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>Prescription drug expenses</u> , <u>premiums</u> , <u>balance-billing</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 https://regence.com/go/WW/Preferred or call 1 (800) 376-7926 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network 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 |
|---|--|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | |
| | <u>Preventive care/screening/immunization</u> | No charge | 35% <u>coinsurance</u> | <u>Coinsurance</u> and <u>deductible</u> do not apply for childhood immunizations from <u>out-of-network providers</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.cvs.com . | Generic drugs | \$7 <u>copay</u> / retail prescription \$14 <u>copay</u> / mail-order prescription | \$7 <u>copay</u> plus remaining balance after pharmacy is paid at network rate | Your <u>prescription drug coverage</u> is administered through CVS. Regence BlueShield assumes no liability for the accuracy of your <u>prescription drug</u> benefits information. <u>Out-of-pocket limit</u> \$1,500 per individual / \$3,000 per family per year. Coverage is limited to a 30-day supply retail and 90-day supply mail-order. For <u>specialty drugs</u> , the first fill is allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy. |
| | Preferred brand drugs | \$30 <u>copay</u> / retail prescription \$60 <u>copay</u> / mail-order prescription | \$30 <u>copay</u> plus remaining balance after pharmacy is paid at network rate | |
| | Preferred multisource brand drugs | \$22 <u>copay</u> / retail prescription \$44 <u>copay</u> / mail-order prescription | \$22 <u>copay</u> plus remaining balance after pharmacy is paid at network rate | |
| | Non-preferred brand drugs | \$60 <u>copay</u> / retail prescription \$120 <u>copay</u> / mail-order prescription | \$60 <u>copay</u> plus remaining balance after pharmacy is paid at network rate | |
| | Non-preferred multisource brand drugs | \$45 <u>copay</u> / retail prescription \$90 <u>copay</u> / mail-order prescription | \$45 <u>copay</u> plus remaining balance after pharmacy is paid at network rate | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Compound drugs | \$30 <u>copay</u> / retail prescription \$60 <u>copay</u> / mail-order prescription | \$30 <u>copay</u> plus remaining balance after pharmacy is paid at network rate | |
| | <u>Specialty drugs</u> | Refer to generic, preferred brand and non-preferred brand drugs above. | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 15% <u>coinsurance</u> after \$200 <u>copay</u> / visit | 15% <u>coinsurance</u> after \$200 <u>copay</u> / visit | <u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met. |
| | <u>Emergency medical transportation</u> | 15% <u>coinsurance</u> | 15% <u>coinsurance</u> | In- <u>network deductible</u> applies to in- <u>network</u> and out-of- <u>network</u> services. |
| | <u>Urgent care</u> | Covered the same as If you visit a health care provider's office or clinic (Primary care visit or <u>Specialist</u> visit) or If you have a test above. | | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| | Inpatient services | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| If you are pregnant | Office visits | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <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 | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | 130 visits / year |
| | <u>Rehabilitation services</u> | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | 60 inpatient days / year 60 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy. |
| | <u>Habilitation services</u> | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | Includes physical therapy, occupational therapy and speech therapy. |
| | <u>Skilled nursing care</u> | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| | <u>Durable medical equipment</u> | 15% <u>coinsurance</u> | 35% <u>coinsurance</u> | None |
| | <u>Hospice services</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | None |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | 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 | • Long-term care | • Routine foot care, except for diabetic patients |
| • Dental care (Adult) | • Routine eye care (Adult) | • Weight loss programs |

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

- | | | |
|---------------------|-------------------------|--|
| • Abortion | • Chiropractic care | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture | • Hearing aids | • Private-duty nursing |
| • Bariatric surgery | • Infertility treatment | |

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 (800) 376-7926. 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 (800) 376-7926 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.

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 (800) 376-7926.

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** **\$300**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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

| | |
|--------------------|-------|
| <u>Deductibles</u> | \$300 |
| <u>Copayments</u> | \$11 |
| <u>Coinsurance</u> | \$800 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$61 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$1,172 |
|-----------------------------------|----------------|

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

- **The plan's overall deductible** **\$300**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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

| | |
|--------------------|-------|
| <u>Deductibles</u> | \$300 |
| <u>Copayments</u> | \$121 |
| <u>Coinsurance</u> | \$673 |

What isn't covered

| | |
|----------------------|-------|
| Limits or exclusions | \$178 |
|----------------------|-------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$1,272 |
|-----------------------------------|----------------|

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

- **The plan's overall deductible** **\$300**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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

| | |
|--------------------|-------|
| <u>Deductibles</u> | \$300 |
| <u>Copayments</u> | \$205 |
| <u>Coinsurance</u> | \$344 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|--------------|
| The total Mia would pay is | \$849 |
|-----------------------------------|--------------|

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

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:

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'déé', t'áá jiik'eh, éí ná hóló, kojí' 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 ដោយមិនគិតល្អល 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 ሊያገዝዎት 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 (टिडिवाइ: 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, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີຜ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajjila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر بہ 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 فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)