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 (866) 240-9580. 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 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual / 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and the following services: office/urgent care visits, outpatient diagnostic test/imaging services, emergency room care, outpatient mental health and substance use disorder, outpatient habilitation services, outpatient surgery, inpatient hospital, maternity or prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	$1,550 individual / 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments, premiums, balance-billed 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 regence.com/go/Preferred or call 1 (866) 240-9580 for a list of network providers.	This plan uses a provider network. 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 nonparticipating 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 Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after $15 copay / visit, deductible does not apply; other services 20% coinsurance		Copayment applies to each office visit only. All other services that are not billed as an office visit are covered at the coinsurance specified, after deductible. Coverage for complementary care (acupuncture, chiropractic care and naturopathic services) is subject to 20% coinsurance after $15 copayment / visit. Copayment does not apply to the out-of-pocket limit. Limited to 24 visits / year for chiropractic care.
	Specialist visit	20% coinsurance after $15 copay / visit, deductible does not apply; other services 20% coinsurance		
	Preventive care/screening/ immunization	$15 copay / visit, deductible does not apply; other services 20% coinsurance		Copayment applies to each office visit only and when immunizations are given. All other services are covered at the coinsurance specified and when immunizations are given without an office visit. Certain cancer screenings are covered at 100% not subject to the deductible. Refer to the Plan Document for specific coverage.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance, deductible does not apply for outpatient services		None
	Imaging (CT/PET scans, MRIs)	20% coinsurance, deductible does not apply for outpatient services		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kpp-rx.com.	Generic drugs	$4 copay retail; $15 copay mail order / option 90		Kroger. Retail: Up to 30-day supply Mail Order: Up to 90-day supply Option 90: Up to a 90-day supply may be obtained only at Kroger owned retail pharmacies for the Mail order copay. (Fred Meyer, QFC, etc).
	Preferred brand drugs	30% coinsurance retail; $30 copay mail order / option 90		
	Non-preferred brand drugs	30% coinsurance retail; $45 copay mail order / option 90		
	Specialty drugs	Refer to generic, preferred brand and non–preferred brand drugs above.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance, deductible does not apply		None
	Physician/surgeon fees	20% coinsurance, deductible does not apply		None

Common Medical Event	Services You May Need	What You Will Pay Your Cost if You Use an In-Network Provider	What You Will Pay Your Cost if You Use an Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	20% coinsurance, deductible does not apply		None
	Emergency medical transportation	20% coinsurance		None
	Urgent care	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% coinsurance, deductible does not apply		None
	Physician/surgeon fees	20% coinsurance, deductible does not apply		None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after $15 copay / office/psychotherapy visit, deductible does not apply; other services 20% coinsurance, deductible does not apply		Copayment applies to outpatient office/psychotherapy visit only. All other outpatient services are covered at the coinsurance specified.
	Inpatient services	20% coinsurance, deductible does not apply		None
If you are pregnant	Office visits	20% coinsurance, deductible does not apply		Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Maternity services for children are not covered.
	Childbirth/delivery professional services	20% coinsurance, deductible does not apply, including for newborn nursery		
	Childbirth/delivery facility services	20% coinsurance, deductible does not apply, including for newborn nursery		
If you need help recovering or have other special health needs	Home health care	20% coinsurance		Limited to 50 visits / year.
	Rehabilitation services	20% coinsurance		Includes physical therapy and speech therapy services.
	Habilitation services	20% coinsurance, deductible does not apply		Neurodevelopmental therapy is limited to services for individuals through age 17. Includes physical therapy and speech therapy services.
	Skilled nursing care	20% coinsurance, deductible does not apply		Limited to 120 inpatient days / year.
	Durable medical equipment	20% coinsurance		Includes glucometers.
	Hospice services	20% coinsurance, deductible does not apply		Inpatient limited to 12 days / lifetime. Respite care is limited to 15 days / lifetime.
If your child needs dental or eye care	Children's eye exam	See Vision Benefits		None
	Children's glasses	See Vision Benefits		None
	Children's dental check-up	See Dental Benefits		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 • 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	• Hearing aids • Non-emergency care when traveling outside the U.S.	• Routine eye care (child)

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 (866) 240-9580. 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 (866) 240-9580 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 (866) 240-9580.

——————*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** — **$200**
- **Specialist copayment** — **$15**
- **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$1,550
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,610**

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

- **The plan's overall deductible** — **$200**
- **Specialist copayment** — **$15**
- **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$178
Coinsurance	$1,372
What isn't covered	
Limits or exclusions	$255
The total Joe would pay is	**$1,805**

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

- **The plan's overall deductible** — **$200**
- **Specialist copayment** — **$15**
- **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$15
Coinsurance	$342
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$557**

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