



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 <https://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 <u>deductible</u>?	\$200 individual / \$600 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 "deductible does not apply" or as "No charge." Deductible does not apply to prescription drugs. Prescriptions are administered by Kroger. More information about <u>prescription drug coverage</u> is available at www.kpp-rx.com .	This <u>plan</u> covers some items and services even if you haven't yet met the deductible 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 deductible. 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>?	\$2,200 individual / \$4,600 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. Separate \$1000 prescription drug out-of-pocket maximum. Prescriptions are administered by Kroger. More information about <u>prescription drug coverage</u> is available at www.kpp-rx.com .
What is not included in the <u>out-of-pocket limit</u>?	<u>Copayments</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/OR/Preferred or call 1 (866) 240-9580 for a list of <u>network providers</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 <u>nonparticipating provider</u> , and you might receive a bill from a <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 <u>nonparticipating 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
		Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u> after \$15 <u>copay</u> / office visit; 20% <u>coinsurance</u> after \$15 <u>copay</u> / retail clinic visit; 20% <u>coinsurance</u> for all other services	30% <u>coinsurance</u> after \$15 <u>copay</u> / office visit; 30% <u>coinsurance</u> after \$15 <u>copay</u> / retail clinic visit; 30% <u>coinsurance</u> for all other services	<u>Copayment</u> applies to each office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . Coverage for acupuncture, chiropractic care and naturopathic services is subject to 20% <u>coinsurance</u> after \$15 <u>copay</u> / visit and <u>deductible</u> for preferred providers; and 30% <u>coinsurance</u> after \$15 <u>copay</u> / visit and <u>deductible</u> for participating and nonparticipating providers. <u>Copayment</u> does not apply to the <u>out-of-pocket limit</u> . 24 chiropractic care visits / year
	<u>Specialist</u> visit	20% <u>coinsurance</u> after \$15 <u>copay</u> / office visit; 20% <u>coinsurance</u> for all other services	30% <u>coinsurance</u> after \$15 <u>copay</u> / office visit; 30% <u>coinsurance</u> for all other services	
	<u>Preventive care/screening/immunization</u>	20% <u>coinsurance</u> after \$15 <u>copay</u> / office visit; 20% <u>coinsurance</u> for all other services	30% <u>coinsurance</u> after \$15 <u>copay</u> / office visit; 30% <u>coinsurance</u> for all other services	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
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 <u>copay</u> retail; \$15 <u>copay</u> mail order / option 90		Your prescription drug coverage is administered through Kroger. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information. 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% <u>coinsurance</u> retail; \$30 <u>copay</u> mail order / option 90		
	Non-preferred brand drugs	50% <u>coinsurance</u> retail; \$45 <u>copay</u> mail order / option 90		
	<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)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	
	<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)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> after \$15 <u>copay</u> / office visit;	30% <u>coinsurance</u> after \$15 <u>copay</u> / office visit;	<u>Copayment</u> applies to each office/psychotherapy visit only. All other services are covered at the <u>coinsurance</u> specified.
		20% <u>coinsurance</u> for all other services	30% <u>coinsurance</u> for all other services	
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you are pregnant	Office visits	20% <u>coinsurance</u> after \$15 <u>copay</u> / visit	30% <u>coinsurance</u> after \$15 <u>copay</u> / visit	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% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50 visits / year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Includes physical therapy and speech therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply	30% <u>coinsurance</u> , <u>deductible</u> does not apply	Neurodevelopmental therapy limited to individuals under age 18. Includes physical therapy and speech therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	120 inpatient days / year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Includes glucometers.
	<u>Hospice services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	12 respite inpatient days / lifetime 15 respite outpatient 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

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.
- Bariatric Surgery

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 ccio.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 1 (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/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFRInsuranceHelp@oregon.gov.

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 (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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,260

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$214
Coinsurance	\$1,696
<i>What isn't covered</i>	
Limits or exclusions	\$255
The total Joe would pay is	\$2,365

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$15
Coinsurance	\$381
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$596

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