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 deductible?	$200 individual / $600 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 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 prescription drug coverage is available at www.kpp-rx.com.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
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?	$2,200 individual / $4,600 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. Separate $1000 prescription drug out-of-pocket maximum. Prescriptions are administered by Kroger. More information about prescription drug coverage is available at www.kpp-rx.com.
What is not included in the out-of-pocket limit?	Copayments, Premiums, balance-billing 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 https://regence.com/go/OR/Preferred or call 1 (866) 240-9580 for a list of network providers.	You pay the least if you use a provider in-network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your in-network provider might use an out-of-network 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		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% coinsurance after $15 copay / office visit; 20% coinsurance after $15 copay / retail clinic visit; 20% coinsurance for all other services	30% coinsurance after $15 copay / office visit; 30% coinsurance after $15 copay / retail clinic visit; 30% coinsurance for all other services	Copayment applies to each office visit only. All other services are covered at the coinsurance specified, after deductible. Coverage for acupuncture, spinal manipulation and naturopathic services is subject to 20% coinsurance after $15 copay / visit and deductible for in-network providers; and 30% coinsurance after $15 copay / visit and deductible for out-of-network providers. Copayment does not apply to the out-of-pocket limit. 24 spinal manipulation visits / year 12 massage therapy visits / year
	Specialist visit	20% coinsurance after $15 copay / office visit; 20% coinsurance for all other services	30% coinsurance after $15 copay / office visit; 30% coinsurance for all other services	
	Preventive care/screening/ immunization	20% coinsurance after $15 copay / office visit; 20% coinsurance for all other services	30% coinsurance after $15 copay / office visit; 30% coinsurance for all other services	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	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	
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		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% coinsurance retail; $30 copay mail order / option 90		
	Non-preferred brand drugs	50% 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	30% coinsurance	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	
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.		None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after $15 copay / office visit; 20% coinsurance for all other services	30% coinsurance after $15 copay / office visit; 30% coinsurance for all other services	Copayment applies to each office/psychotherapy visit only. All other services are covered at the coinsurance specified.
	Inpatient services	20% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	20% coinsurance after $15 copay / visit	30% coinsurance after $15 copay / 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% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	50 visits / year
	Rehabilitation services	20% coinsurance	30% coinsurance	Includes physical therapy and speech therapy.
	Habilitation services	20% coinsurance, deductible does not apply	30% coinsurance, deductible does not apply	Neurodevelopmental therapy limited to individuals under age 18. Includes physical therapy and speech therapy.
	Skilled nursing care	20% coinsurance	30% coinsurance	120 inpatient days / year
	Durable medical equipment	20% coinsurance	30% coinsurance	Includes glucometers.
	Hospice services	20% coinsurance	30% coinsurance	12 respite inpatient days / lifetime 15 respite outpatient days / lifetime

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 your child needs dental or eye care	Children's eye exam	See Vision Benefits	See Vision Benefits	None
	Children's glasses	See Vision Benefits	See Vision Benefits	None
	Children's dental check-up	See Dental Benefits	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.)		
• Cosmetic surgery, except congenital anomalies	• Long-term care	• Routine eye care (Adult)
• Infertility treatment	• Private-duty nursing	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Hearing aids
	• Chiropractic care	• 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 ext. 61565 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 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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$2,000
What isn't covered	
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$214
Coinsurance	$1,696
What isn't covered	
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$15
Coinsurance	$381
What isn't covered	
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.